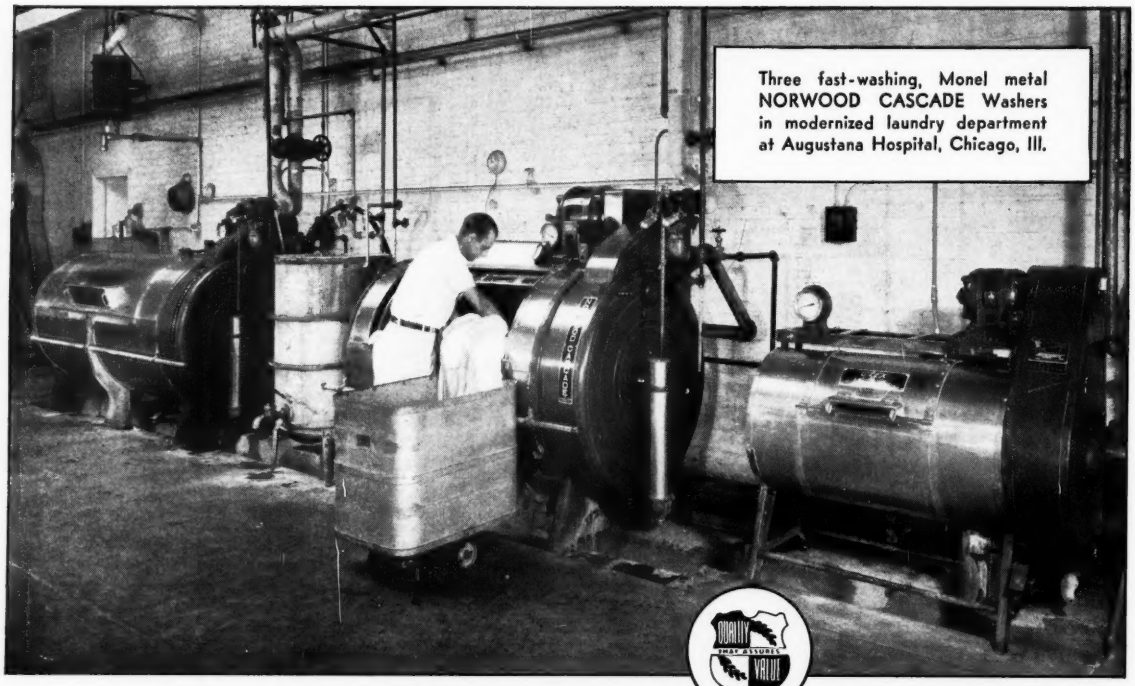
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

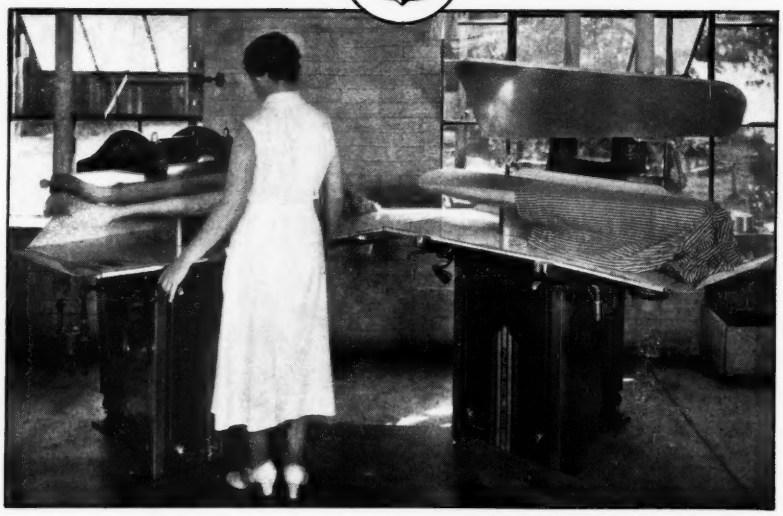
FEBRUARY, 1944



Three fast-washing, Monel metal NORWOOD CASCADE Washers in modernized laundry department at Augustana Hospital, Chicago, Ill.

AUGUSTANA *found the* ANSWER

by modernizing with American equipment



Efficient unit of two high-speed ZARMO Presses for pressing uniforms and other apparel at Augustana Hospital.

"ASK FOR A CANADIAN LAUNDRY ADVISER"

At Augustana Hospital, Chicago, increased clean-linen demands were crowding the laundry. An American Laundry Adviser was called in. He made a complete survey of the hospital's laundering needs, then submitted recommendations for modernization with high-production equipment.

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Perhaps you have a laundering problem. You, too, can find out, *in advance*, what can be accomplished in the way of economies and benefits. We invite you to avail yourself of the services of a Canadian Laundry Adviser. No cost. No Obligation. Write us today.

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Why Hospitals Equip for Artificial Fever Therapy

HUNDREDS of institutions today are equipped for artificial fever therapy, because many staff physicians advocate this method—either alone or in combination with drugs—for the treatment of certain conditions such as primary and cerebrospinal syphilis, sulpha-resistant gonococcic infections, arthritis, asthma, and undulant fever. ▶ ▶ ▶ Wherever the G-E Fever Cabinet is used, you'll observe that it is almost invariably—and preferably—in combination with the G-E Inductotherm. Preferably, because in this method of treatment the Inductotherm serves primarily to produce the desired degree of fever by *electromagnetically* inducing heat within the tissues, and the fever level is then maintained with a relatively low cabinet temperature. The method assures not only effective treatment, but also maximum comfort and safety for the patient. Less irritability and discomfort of the patient facilitates the administration of adequate treatment. ▶ ▶ ▶ So that you may fully evaluate fever therapy and thus appreciate the advantages to your hospital of being so equipped, we shall be glad to send reprints of authentic articles which cite interesting clinical experiences in the treatment of various conditions. ▶ ▶ ▶ *Ask for Fever Therapy Reprint Set No. K82.*

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Contents

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FEBRUARY, 1944

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CCAB

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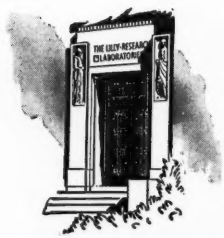

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Captain of the men of death

Physicians have not forgotten that only a few years ago pneumonia often was defined as "Captain of the men of death." This is the month when the incidence of the pneumococcal pneumonia is highest, but, thanks to the comparatively recent introduction of the sulfa drugs into medical practice, mortality has sharply declined. The physician may prescribe sulfathiazole or sulfadiazine according to his choice. A full range of dosage forms and sizes is available under the Lilly Label.

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Zero Hour...

Black of night. A ringing phone . . . another call to arms. Instinctively, the doctor answers. For him it is the zero hour. An accident at a plant. A war-worker seriously injured. Once again begins a battle in the war that never ends . . . the crusade against disease . . . man's untiring enemy.

And science marches by the doctor's side . . . helps fight the foe with modern weapons. Take x-ray . . . a good example. Radiographs may save the worker's life . . . help chart a course that leads to successful treatment and a speedier recovery.

* * *

Today, the satisfactory diagnostic radiograph is the rule rather than the exception. One reason is that radiographers recognize that a sharp, contrasty negative depends to a large extent upon highly efficient intensifying screens. Screen care and replacement are important. Screens that are dirty, scratched or stained produce inferior results.

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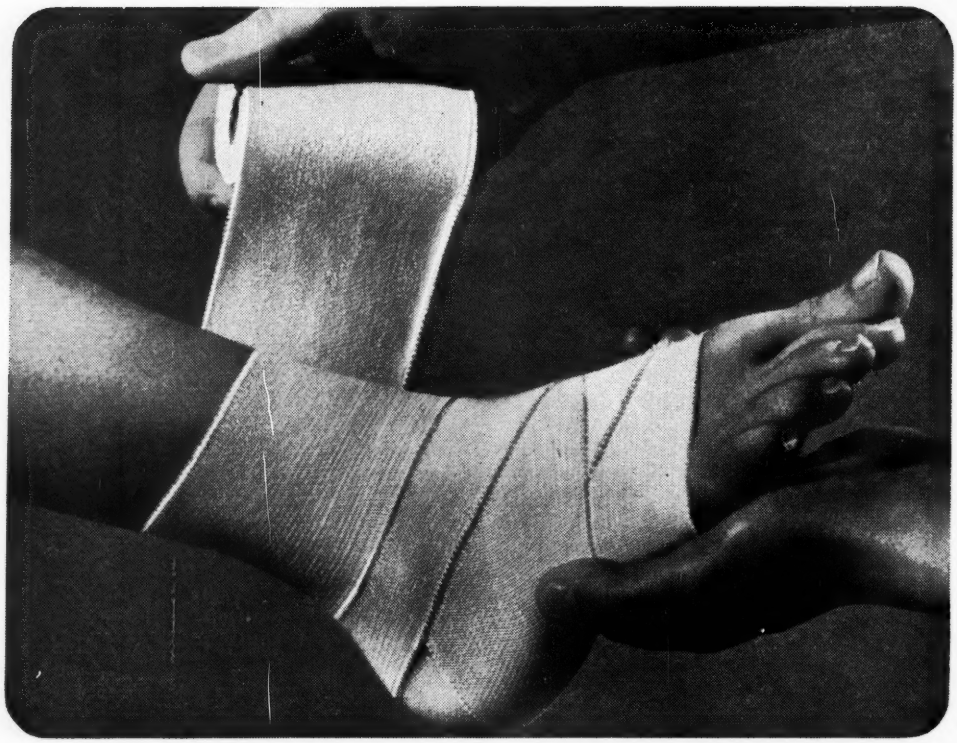

'Elastoplast' in the treatment of Sprains

PAIN is relieved, swelling controlled and hæmatoma formation prevented by the use of an 'Elastoplast' Bandage applied over the joint, muscle or ligament.

Early application permits the patient to use the injured part and shortens the period of incapacity.

The bandage should extend for several inches above and below the affected part; for example, in sprains of the ankle joint, it should commence at the base of the toes and finish at the upper part of the calf.

The tension of the bandage must be considerable—a loosely applied bandage fails to relieve symptoms.

In the 'Elastoplast' Bandage the combination of the particular adhesive spread, with the remarkable *stretch* and *regain* properties of the Elastoplast' cloth, provides the exact degree of compression and grip

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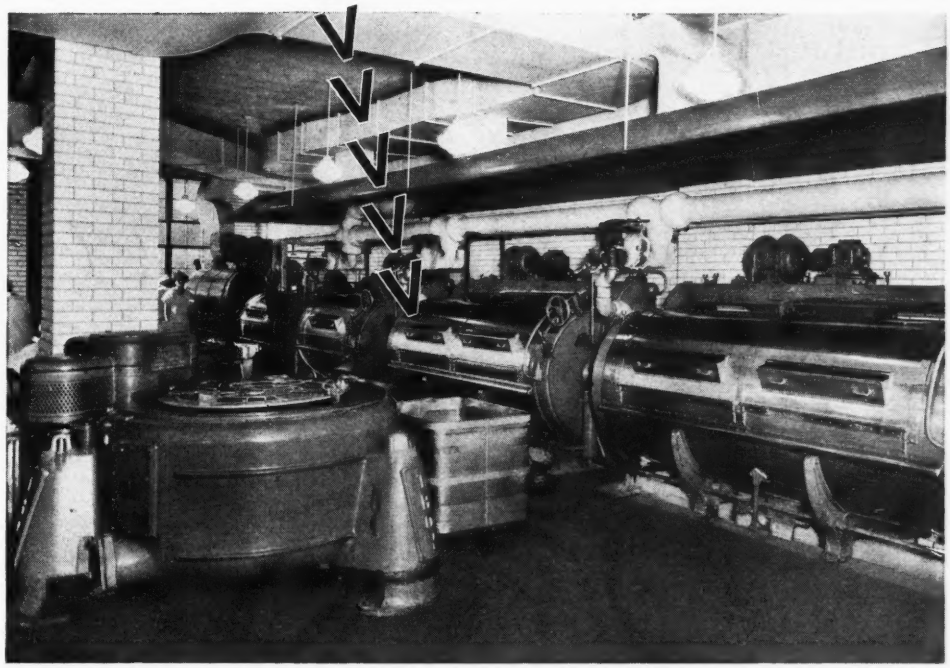
If Laundries gave Service Stripes MONEL WASHERS would rate an army of V's



FURLOUGHS are not asked for . . . or needed by Monel washers.

Today . . . despite the increased wartime demand upon them, they work longer hours and as faithfully as ever.

As an example, here are typical quotations from large laundry operators.

" . . . our Monel washing machines have been installed from 14 up to 18 years and are still in service. No repairs have as yet been necessary, and the performance of this equipment has been to our entire satisfaction . . . "

And

" . . . Monel washing machines, installed here some ten years since, have been running continuously since their installation, six days a week, and are giving complete satisfaction in every respect . . . "

Veteran Monel washers are doing their share in servicing the nation's linen. They help safeguard the health of a Canada at war.

Improved post-war laundry equipment is being designed today. The best will feature Monel. Its service record recommends its preference.

INCO MONEL TRADE MARK

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2/3 NICKEL + 1/3 COPPER

Wash up laundry machinery problems for years to come by specifying Monel.

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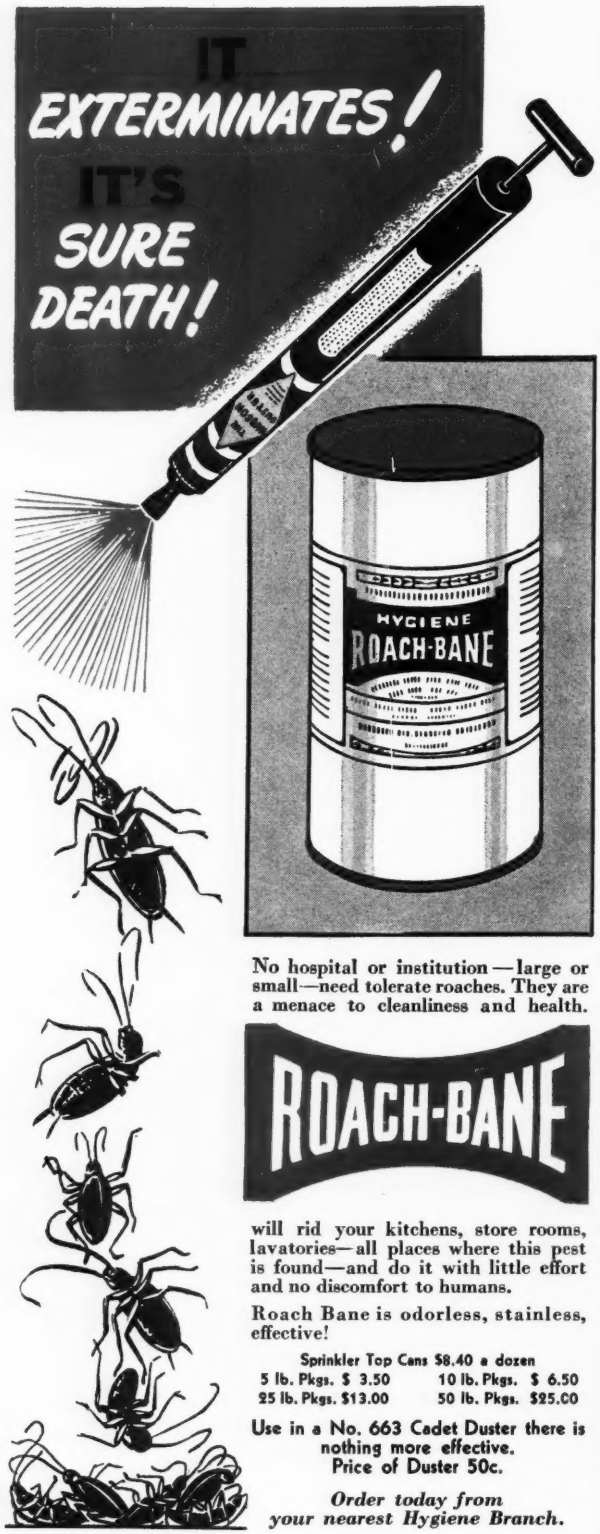

No hospital or institution—large or small—need tolerate roaches. They are a menace to cleanliness and health.

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will rid your kitchens, store rooms, lavatories—all places where this pest is found—and do it with little effort and no discomfort to humans.

Roach Bane is odorless, stainless, effective!

Sprinkler Top Cans $8.40 a dozen

5 lb. Pkgs. $ 3.50	10 lb. Pkgs. $ 6.50
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Across the Desk

By C. A. E.

Hospital Building After the War

A survey among institutions in the United States showed that 92 per cent of them plan to remodel, re-equip, refurnish or expand facilities when supplies and equipment are available. These plans call for the spending of more than two billion dollars by hospitals to help make up the national deficiency of 100,000 beds.

In Ontario, according to Mr. C. J. Telfer, Inspector of Hospitals, there is hardly a community that is not planning some form of hospital addition or construction after the war.

* * *

Occupational Therapists Exhibit

An exhibition depicting occupational therapists at work with patients in Canadian civilian and military hospitals was held at the Canadian Handicrafts Guild in Montreal in January. The display consisted of photographs taken by the Canadian Pacific Railway Company, an exhibit loaned by the British Ministry of Information and handicrafts made by patients in hospitals. "Occupational therapy is the only dose the patient gets more of as he gets better", said Miss Ethel Clarke, consultant for Ontario of the Canadian Association of Occupational Therapists, who opened the exhibition.

* * *

Sales Manager for Colgate-Palmolive

Ralph A. Hart has been appointed Sales Manager of the Colgate-Palmolive-Peet Company Limited. Mr. Hart joined the company as a salesman twelve years ago. He was promoted to District Sales Manager for Ontario and later spent four and a half years as Managing Director of the Company in India. C.-P.-P. Products have long enjoyed wide acceptance in the institutional field, for whom a varied range of cleaning materials is produced.

Ralph A. Hart

* * *

Birth of Blotting Paper

We have had considerable to do with paper over the years, apart from printing and publishing. Some twenty or more years ago we helped to make sizeable quantities of newsprint, coated paper, wallpaper and kraft paper.

"Let everyone ascertain his special business or calling, and then stick to it, if he would be successful"

Benj. Franklin

Specialization is the secret of Master success. By concentrating entirely upon hemostatic ring forceps and surgical scissors, Master has performed a modern miracle in producing surgical instruments of the finest precision.

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We are now in a particularly good position to give you prompt service on your 1944 requirements.

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Just recently, however, we learned how blotting paper was first made. It came about in this way: a disgruntled workman in a paper mill deliberately omitted to include some necessary chemicals in a formula (probably sizing) with the result that what was supposed to be writing paper turned out to be entirely unsuited for that purpose. The ink refused to remain on the surface and was absorbed into the texture of the paper. In those days fine sand was employed to dry the ink and the paper manufacturer suddenly realized that here was a new use for his products. Blotting paper was therefore the happy result of an unhappy workman's mischevious designs.

* * *

An Unfortunate Condition

Among Canadian markets that are far from the saturation point is that provided by public libraries. A survey conducted by the Dominion Bureau of Statistics shows that well over half of the Canadian population is still without public library service as compared with one-fourth in the United States and less than one per cent in Britain. Expenditures on books in this country continue to be less than 20 cents per capita, while it approaches 30 cents in Britain and is more than 40 cents in the United States.

* * *

We're Sold on this Hobby!

To anyone who appreciates fine mechanism, graceful designing and the romanticism of by-gone days, what hobby could be more intriguing than the collecting of exquisite old clocks?

Mr. W. C. Bland, who from time to time illustrates and describes in his advertisements in the Journal some of the beautiful old case clocks in his possession, has received many letters from appreciative readers.

Example of text: "We are going to tell you about another long case clock this month. Ours was made by Geo. Ashton of Tidswell, England, in 1681. It is a thirty hour clock, having but one hand, and it strikes on the hour with a deep sonorous tone. It also has a date dial and even after 260 or more years of faithful service it can still be depended upon for accuracy. If we were romantic, we could write a story for one to dream over. Imagine, if you can, hearing the voices and the gossip of that period! And the noises of London; the alarums and excitements; Wolfe's capture of Quebec; the Boston Tea Party; Geo. Washington; Napoleon's exploits, and so on until today. And during it all our "Old Fellow" continues to stand and listen, hearing again the sounds of war, but also about the plans for peace."

* * *

Unsatisfactory Material

An article, written by the president of a college for women, tells us (as we already know from sad experience) that student nurses who have completed high school are sometimes "unable to write a complete sentence, can't multiply or divide, and don't understand decimals, either". Well here is one problem that neither hospitals nor schools of nursing can reasonably be expected to solve, but are justified in politely handing back to the teaching profession for appropriate action.—*Canadian Nurse.*

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No. 3 Rapid Tumbler Dryer — capacity 32 pounds. Cylinder 36" x 30". Equipped with gas or steam heater only.

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(less sales tax to hospitals on Govt. list).

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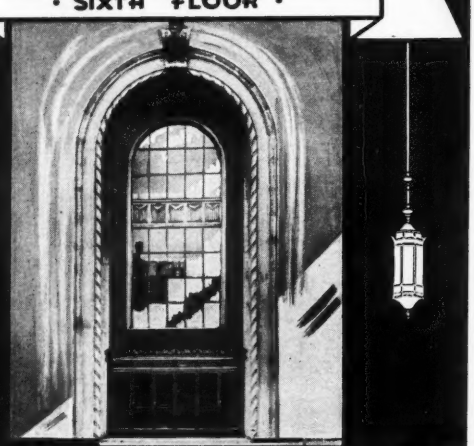


EATON'S - COLLEGE STREET

PHONE TR. 1257

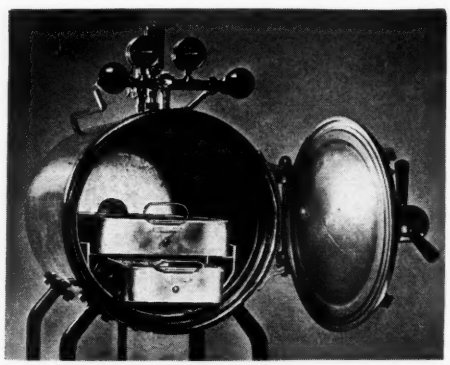
Is This Justice?

We are told that a certain young married woman in Halifax had a gentleman friend who wished to give her a Christmas gift. A beautiful set of twin silver foxes was duly received. As the pleased recipient just couldn't walk in on her husband without an explanation (blind as some husbands are to wifely finery) something good had to be concocted. The result was that the furs were checked at the railroad station and the "found" check, in due course, was presented to the husband so that he could claim the "lost" parcel. Unhappily for the lady with divided affections, the husband happened to have a lady friend. To her he presented the furs and to his wife he gave, as the checked article, a gentleman's umbrella.

* * *

Double Duty Sterilizer Assembly

Wilmot Castle Company, Rochester, N.Y., announce a new convenient "Duplex" Assembly comprising a lightweight Tray Frame and two Instrument Trays with Tray Hooks, which permit any 14", 16" or 20" diameter Dressing Sterilizer to do double duty as a Pressure Instrument Sterilizer. This assembly weighs so little and is so easily handled that it can be put in place or removed in an instant and can just as readily be laid aside when not in use.



* * *

Are Your Bulletin Boards Effective?

Quite frequently "Bulletin Board" information is not presented in a manner calculated to impress the reader. As a rule, these notice boards are not used extensively enough and often they are dingy and too small in size. Suitably framed panels in good locations and containing carefully worded messages, giving the reasons for the policies indicated, and expressed from the employees viewpoint and in terms of the employees interest, when possible, have proven sound investments.

* * *

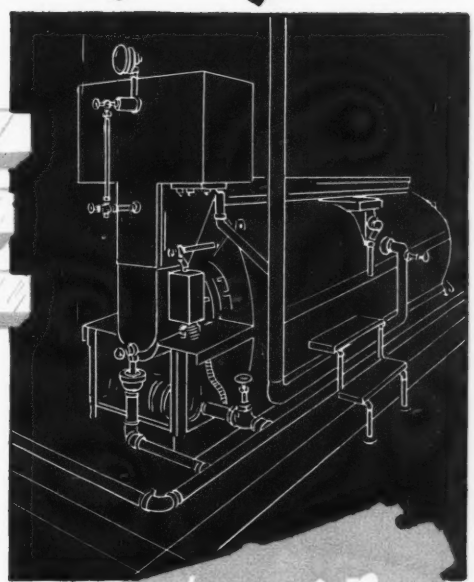
Miss Speers Goes to Washington

Miss Anna Speers, formerly Director of Requirements and Nutritionist, Foods Administration, Wartime Prices and Trade Board, has taken up a new post as Assistant to the Board's representative in Washington. Miss Speers' work will deal principally with food problems.

How much do you pay for ICE?

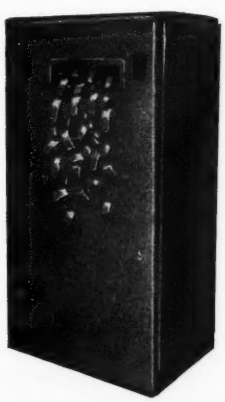
$3.00 a ton

by the old-fashioned method



75¢ a ton

with a Frosty FlakIce Machine



WHETHER you use 500 lbs. or ten tons of ice for packaging each day, you can have ribbons of ice made with the Frosty FlakIce machine in 60 seconds at the touch of a button—and costing only 75c a ton. Before this war, ice for packaging cost $3.00 a ton or more—after going through the double process of making ice in bulk and then breaking it up mechanically afterwards.

Frosty FlakIce ribbons are far more efficient. They pack closer around perishables and literally form an ice blanket. Foods are kept colder and cleaner without ever having been touched by human hands.

Enquire about a Frosty FlakIce Machine *today*. There are various models with varying capacities to suit your need.

York refrigeration air conditioning

CIMCO-YORK

REFRIGERATION, AIR-CONDITIONING AND HEATING

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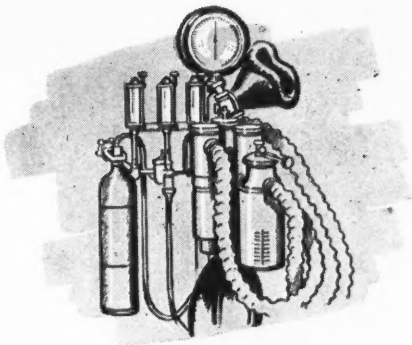

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for quick, sustained action in combating hypotension without appreciable systemic side effects use this synthetic vasopressor

Neo-Synephrine

Hydrochloride

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Supplied in 1 c.c. ampuls, and in rubber-capped vials containing 5 c.c. of a sterile 1% solution. Average subcutaneous dose: 0.5 c.c.

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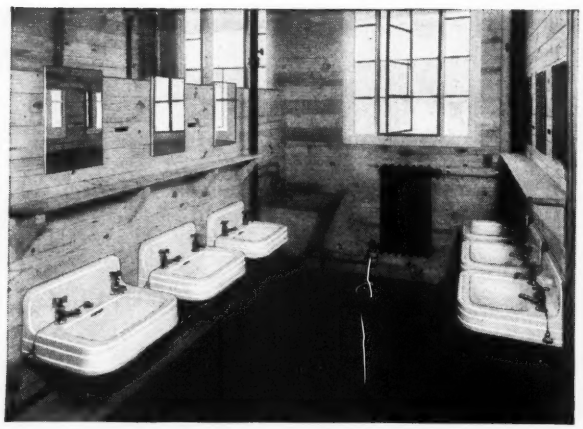
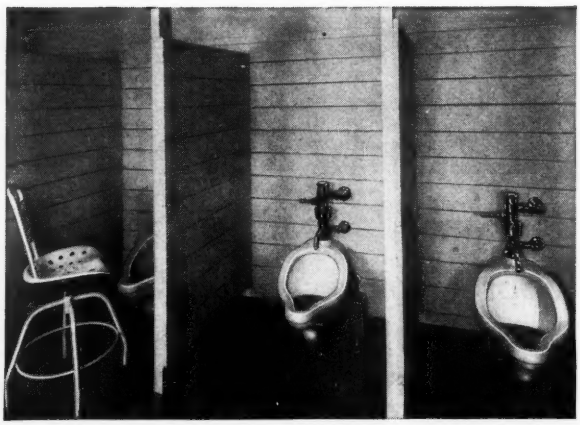
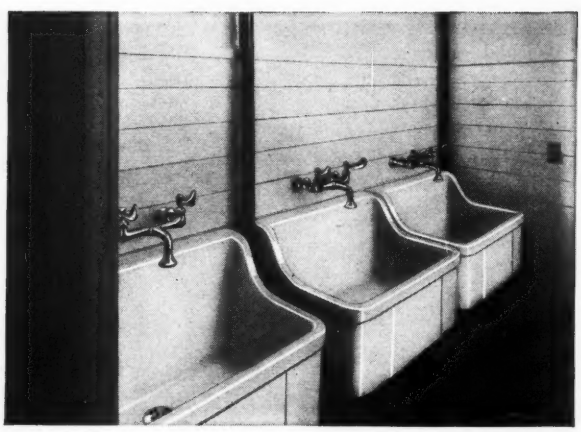
For Army Hospitals too
IT'S CRANE!



★ *Lavatories in wash room*



★ *Prophylactic Receptors in G-U clinic*



★ *Scrub-up and Surgical Sink for operating room*

★ *Scrub-up and utility sink with water heater in morgue*

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, February, 1944 Vol. 21 No. 2

A Trustee Analyzes His Job

By Ald. H. D. McPHERSON,
Chairman of the Board,
Regina General Hospital

GRATUITOUS service to your local hospital by being a member of the Board of Governors or Trustees is, in my opinion, one of the most worthy, one of the most pleasant, and one of the most responsible duties of community life, providing, of course, that you apply your ability, your interest and your effort to the maximum degree in the interest of the institution.

Every normal man and woman has a desire to serve the community in which he lives; those who are blessed with the privilege—and it is a privilege—of serving on a hospital board, should see to it that they are not just deadwood on the Board but should realize that they must be energetic, aggressive and alive to the requirements of the institution. When a man or women becomes a member of a hospital board, it cannot be expected that he will have a full working knowledge of the institution, but if the trustee enters the work with the right spirit of actual desire to serve—it is enough. Hospitals are complicated machines and demand close study and constant watching. They don't "just happen", they don't run themselves; if the new trustee is conscientious and imbued with a desire to serve, he will gradually grasp sufficient of the knowledge and data required to render a service to the institution.

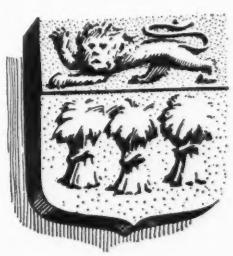
Perhaps the most important qualification of a good trustee is the spirit, the desire, to serve intelligently—to serve the community specifically and mankind generally. This does not mean that we should go out with the maudlin idea that we are putting on a crusade to convert the community to doing a lot of good, but does mean a keen desire on one's own part to contribute earnestly and efficiently.

A second qualification is the ability to really work towards accomplishment, to give unselfishly of one's time and effort in the interests of the hospital and to do so without thought of reward in either prestige or business.

The standing of the trustee in his community is a third and important consideration. He should be a person whose integrity is unimpeachable and who, by his contacts with the business world, has a broad view of the needs and aims of the institution he is about to help manage.

What business classification should he hold? That does not matter; he might be a banker, a merchant, a professional man, or any one of the callings that go to make a community centre, but one qualification he must have—he must have a sane outlook on life itself; bigots, narrow-gauged hypocrites and self-seekers should not be considered as suitable material. They will always be a hindrance rather than a help.

Attendance at all the board meet-



An address at the October convention of the Saskatchewan Hospital Association.

ings is essential, of course, but it is not alone sufficient. Neither is it sufficient that the members formulate plans and policies for the executive of the Board. They must select one they check the financial statement of receipts and expenditures, or see that the buildings and grounds are adequate and kept in a proper state of repair, or know that the proper relations exist between the board and the medical staff; all these things they must do—but one big job still remains. A responsibility that rests squarely on the shoulders of the trustee is that of being a "public relations officer" between the institution and the people of the commuunity in which the hospital is situated. It is the responsibility of each trustee to see that the institution is held in the highest regard from every viewpoint. In order to accomplish this there are many things the trustees must do.

Relations to Superintendent

First they must satisfy themselves that they have a competent and reliable executive officer, or superintendent. This is most important, as upon this one thing depends the success or failure of all the other efforts of the board. They must select one whose integrity is above reproach; one who has the courage of his convictions; one who has a thorough knowledge of all departments of the institution; who has a technical knowledge of equipment and procedure as well as the ability to deal with personnel, both lay and professional. The board must have an executive officer in whose ability they have absolute confidence, having found him and placed him in charge of the institution, they must so conduct themselves that the confidence they have placed in him is returned to them. This mutual understanding is most essential if the best results are to be attained—and only the best results will do.

Under no circumstances must the trustee usurp the authority or perogative of the superintendent. Under no circumstances must the trustees discuss matters of internal management with the employees without the full knowledge and consent of the superintendent, nor should they receive or discuss complaints from patients. These matters should all come to the superintendent and through him to the board. There is nothing that will more rapidly and more completely destroy an organization than such practice.

Legal Liability

What is the trustee's personal liability with regard to accidents to the staff, to the patients, or to the public, or claims for damages arising from any one of the many causes which would place the hospital on the defensive in a law suit for damages? He is in just the same position as he would be on the board of any other incorporated or limited liability company. Fortunately there is insurance available to cover almost any emergency, liability insurance of all kinds, insurance against malpractice suits, etc. Prudent trustees will ensure that adequate protection be afforded their hospital in this regard. But if a trusted employee absconds with the funds, or the hospital burns down, or there be any fire loss and it is proven that the trustees have been negligent in their duty in not protecting the property placed in their charge, then they are liable and may have to defend themselves against a claim for damages. So again I say, take advantage of the various types of insurance available to protect the hospital, and in some cases yourselves, against suits for damages.

The Board of Trustees should never forget that the hospital was built and equipped with *one* definite purpose in mind—the care of the sick and the maimed. The care of the patient is paramount and it is the Board's obligation to see that every person who enters the institution should be satisfied with the treatment received, that no just complaint goes uncorrected and that no unjust criticism be allowed to go unanswered. Remember, any stigma placed on the hospital also rests squarely on the shoulders of the Board of Trustees. Remember that the patient has placed his life and his future welfare in the hands of the hospital. He must be returned to health as soon as possible. He must have the advantage of the best medical and nursing care in the community. Second best or abbreviated service will not do. All available equipment must be at the disposal of the doctors to see that exact

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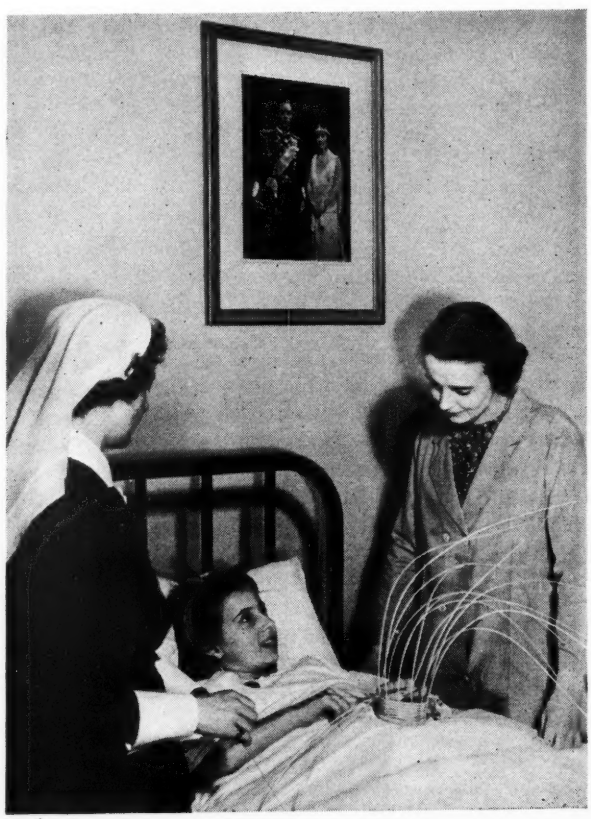

Occupational therapy has been of the greatest assistance in the treatment of children at the Hospital for Sick Children at Toronto and its country-branch at Thistletown.

Does Agriculture Really Prefer

State Medicine to Health Insurance?

DOES agriculture fully appreciate the significance of certain recommendations made in its name? Have spokesmen for agriculture played fair with those whom they represent? Have they told their members that they are working for state medicine and against health insurance? Have they admitted to the thousands of farmers who have worked so hard to pay off mortgages that what they are advocating paves the way directly to state ownership of all land?

The evidence is right before us. The Canadian Federation of Agriculture, on behalf of its various provincial divisions and allied organizations, has stated repeatedly, and particularly before the Special Committee on Social Security at Ottawa, that it wants the entire cost of health services to be borne by the federal treasury. Personal contributions and payments by the employer are out—all of the $260,000,000 (or more) must come from federal funds.

In other words, although these spokesmen refer repeatedly to "health insurance" they are not talking about health insurance at all. It is absurd to talk about "health insurance" if the individuals do not make personal payments. What they are talking about is out-and-out "state medicine".

This has serious implications. One-hundred-per-cent state finance is bound to result in state control. To talk of such a plan remaining under an "independent commission" is but wishful and idle thinking. "He who pays the piper calls the tune." Within a few years the whole health machinery would be controlled and directed by the government; the professions and those providing the services would become state employees; the story of hospitals in Germany would be repeated and all Sisters' and other voluntary hospitals would be gradually stifled and replaced by state institutions.

Once established in the field of health, the principle of state control would be extended. One by one other utilities and public services would be taken over. Ultimately, a communistic state would eventuate, with even the farms confiscated and the farmers reduced to tenants at the pleasure of the government in power. This may seem far-fetched, but it is by no means so.

To say that all people contribute fairly by federal payment is open to question. It would likely mean a heavier burden on salaried workers and wage-earners whose total income could be more readily computed. Perhaps that is anticipated.

Of major importance, it would mean a lessened feeling of personal responsibility for the economical and efficient operation of the measure. The very fact of having to make a personal contribution towards the support of a service has been amply proven to stimulate increased personal responsibility for its success. What we get for nothing, or think we get for nothing, is seldom valued. Costs of a non-contributory plan would probably mount rapidly and far outweigh the alternative costs of collection under health insurance.

Actually, the state—federal and provincial—would be paying a substantial share of the cost under a contributory plan, for it is proposed that a sizeable proportion of the total cost be contributed from governmental sources—for the extensive public health and preventive activities outlined, for the coverage of those unable to pay, and to subsidize and reduce the premiums of contributors. Although only a fraction of the total cost, these direct contributions mean all the difference between a state-controlled system and one wherein the public retain a fair share of control.

With the obvious need for better health facilities in rural areas all of us are in full sympathy. With many of the C.F.A. suggestions for the betterment of such, we are quite in accord; in fact, many of these proposals have been urged quite independently by the hospital, medical, nurse, public health and/or other committees. Certain recommendations suggested by the Canadian Federation of Agriculture, as, for instance, the setting up of health centres, had already been proposed by the Canadian Medical Association and was urged originally by the British Medical Association. It is agreed, too, that only by some form of health insurance can certain present problems be overcome.

What we need in Canada is a system of health care that will be a *partnership of personal effort and state assistance.* There are certain health developments that can best be undertaken by the state; there are other features which are more effective if the individual citizen remains an integral factor. Such a basis of interest, if properly worked out, can give us maximum benefits with a minimum of weaknesses. This can best be achieved by a contributory form of health insurance — not by state-financed state medicine.

Protecting the Personnel—

I. The General Staff

By M. J. McHUGH, M.D.,
Physician-in-Chief,
Toronto Hospital, Weston, Ont.

IT has long been recognized that the duty of protecting the personnel of a hospital for tuberculosis is just as important as treating the patients. This work is usually divided into two parts, the first being to rigidly enforce rules for patients calculated to make them keep their source of infection under control, and the second to teach all employees in contact with or caring for patients how to protect themselves.

I think it is very important that everyone from the physician and nurse right down to the cleaner be given a course of instruction in tuberculosis, its infectiousness, and its curability and on how to protect themselves from it if they are dealing with the disease for the first time. Great dread or fear of the disease should in this way be removed, but people must be taught that there is some danger; in other words, they must be taught to have a reasonable or healthy respect for it and never to become careless from long experience with patients.

At Weston we start this educational routine with the newly-admitted *patient.* He gets his little book of rules and is told he must study, understand and strictly observe them. If he becomes careless he is remined again and again and finally we tell him that if he continues to cough without covering his mouth he will get very little attention from doctor, nurse, ward aide or orderly. The names of all patients in each ward having positive sputum, or likely to have positive sputum, are clearly marked on the nurse's desk and this list is revised from time to time. Nurses and doctors are instructed to wear masks when they are examining or in attendance on patients with positive sputum who are too ill to cover their mouths or too careless to do so. In the case of the latter type who repeatedly refuse to take this precaution we threaten expulsion from the hospital and this frequently has the desired effect.

So much for patients. Now as to *employees:* When an employee who will in any way come in contact with patients joins the staff, he is given a tuberculin test and an x-ray of the chest, whether the tuberculin test is positive or negative. A card is made out for each one and filed in a special filing section. If the individual is delicate looking or shows symptoms of disease or infection, a complete physical examination is done and appropriate treatment is given. In prewar days, of course, we rejected frail or delicate individuals, even though organically sound. Charts are kept for all employees examined, and we have a male staff physician looking after the male employees and a female physician for the women. From the nurses on down, employees get a definite number of hours of instruction about tuberculosis, stress being laid on its infectious character. They are taught also how to take care of themselves and to see that patients obey regulations. When attending very ill patients or careless patients with positive suptum, they wear paper masks which fit into a holder and are discarded after use. We are now requiring cleaners to wear masks in rooms of the above type of patient. Employees have an x-ray every six months, or more frequently if indicated. They are instructed and encouraged to keep themselves in good condition, to report when ill and to rest in their rooms when they have a cold or

The Ruddy and Medical Building at Weston.

(Concluded on page 58)

of a Tuberculosis Hospital

II. The Nursing Staff

By ELLEN EWART, Reg. N.,
Superintendent of Nurses,
Mountain Sanatorium, Hamilton, Ont.

WHAT constitutes an adequate aseptic technique for a tuberculosis service? Should a strict communicable disease technique be used, or would a modified form be sufficient? No aseptic technique can be adopted bodily and made to fit all situations, because (1) the clinical condition of the patient varies from those confined to bed to those on full exercise and (2) the amount of nursing service available varies.

The protection offered the personnel at the Mountain Sanatorium is as follows:

(i) The personnel are all conscious that they are caring for tuberculosis patients and that tuberculosis is an infectious disease which can be controlled by using proper technique.

(ii) *Education* is of greatest importance. This may be divided into two groups:

Education of the Personnel

An outline of the isolation technique is kept available in the Ward Procedure Book. The supervisor reviews this with each nurse when she is taken on the sanatorium staff. The housekeeper reviews the procedure with the sub-staff.

A series of lectures on tuberculosis is conducted twice yearly. All personnel are requested to attend.

As an illustration let me mention the mask technique. This is the one which is most often disregarded.

The value of a mask depends entirely on the manner of its use.

It should not be worn after it becomes moist. The ideal rule is to change it after caring for each patient. A mask must not be pulled away from the face and allowed to hang around the neck until needed again. Whether clean or used it should not be kept in a pocket. It should be worn when in close contact with all patients and put on and adjusted with clean hands. It should not be touched again until untied. It should not be touched after removal but dropped into a container for that purpose.

Education of the Patients

Here we teach the control of sputum, including the precautions to take when expectorating, the use of the cup, the control of droplets and the control of coughing.

We teach personal hygiene—this includes care of the hands, conduct towards visitors and general measures.

The success of teaching patients and staff depends on constant supervision, repetition, ability of the teacher to present her material in a simple and interesting manner, and the intelligence of the patient and the employee and their willingness to accept teaching.

The health of the personnel receives special attention. The personnel are asked to report to the doctor at the first sign of illness. The old idea that they must not report off unless there is an actual rise of temperature is discouraged. In order to combat exhaustion from overwork, which would lower resistance, each member of the staff is given one day off each week.

Summary

The personnel are *conscious* that they are caring for *tuberculosis patients;* therefore they are taught and will, I trust, use, isolation technique with all patients, whether they have positive sputum or not. The diagnosed case is not a great danger.

Through education we try to make the personnel realize that each one

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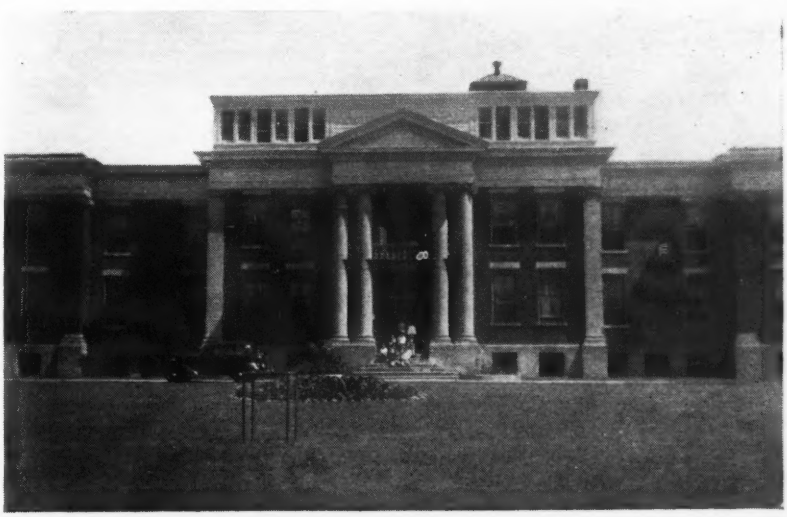

The Queen Mary Hospital for Children.
One of the buildings at Weston.

The Wartime Bureau of Technical Personnel *and its Relation to Hospitals*

By H. W. LEA, Director,
Wartime Bureau of Technical Personnel

THE Wartime Bureau of Technical Personnel is a branch of the Federal Department of Labour. It was created to facilitate the placing of skilled technical personnel in those positions where they could be of most service during the war period.

In connection with the Bureau's operations, the words "technical personnel" or "technical person" are used in a specific sense, rather than with the broader meaning often associated with the use of the word "technical". For example, many institutions, including hospitals, are often referred to as having technical staffs and the reference is meant to include technicians with various degrees of skill, particularly certain highly skilled labour—such as laboratory, electrical or engine-room employees or, in fact, anybody who may be distinguished from the other general classifications, such as housekeeping, clerical, etc.

In the manpower regulations administered by the Department of Labour, however, technical persons are those only who come within a definition which is set out as a schedule to the civilian manpower regulations. Broadly speaking, this schedule limits the classification "technical person" to those who either hold a degree from a recognized university in any branch or engineering or pure science, and those who are technically qualified members of professional institutes or associations, either engineering or scientific.

It will be seen from the above that the work of the Wartime Bureau of Technical Personnel is not concerned with such people as physicians, nurses, pharmacists, laboratory technicians, or "hospital engineers", but merely with those members of hospital staffs who come in the somewhat narrow classification defined in the preceding paragraph.

Dietitians

There has been some uncertainty in the hospital field with respect to the status of dietitians under this Bureau. It will readily be seen however, that a degree in household science or home economics (which embraces a preponderance of subjects which fall in the field of natural science), provided the degree is held from a recognized university, would qualify the holder as a technical person. It should be noted that the holding of a diploma from a college which does not give the full university course does not qualify the holder as a technical person. Where a dietitian is a technical person, the approval of the Minister of Labour (through the Bureau) must be obtained before a contract or arrangement for the services of such a person is concluded. This applies to the appointment of student dietitians as well as to other appointments, since the regulations refer to "making use of the services of a technical person".

Procedure

The primary purpose of the Wartime Bureau of Technical Personnel is to assist in finding people with the right type of training for vacancies which occur in essential undertakings. The procedure followed by the Bureau differs from that of National Selective Service somewhat. Under National Selective Service a prospective employee secures a permit to leave his present work or to seek new employment or to be interviewed regarding new employment. Under the regulations governing technical persons the only permit that is required is that which the prospective employer must secure before making use of the services of a technical person. Therefore, provided the technical person's services are available, no permit is necessary for either party during the negotiation stage. Permits to employ technical persons are normally granted only after the Bureau has been satisfied as to the qualifications of the technical person involved, the availability of the services of such person, and the essentiality of the work to be undertaken. Once these conditions are met, the permit is usually issued without any delay or further formality. Particular note should be taken of the circumstances under which a person's services are considered available, as set out below.

What Each Person Must Do

1. Register by means of the questionnaire provided by the Wartime Bureau of Technical Personnel if this action has not been taken.

2. Report to the Bureau that his services are available, if he wishes to enter into a new contract of employment. A person's services are considered available only if he is (a) unemployed; (b) engaged in work other than of an engineering or scientific nature; (c) has given notice as of a definite date; or (d) has written permission from his present employer to negotiate for work elsewhere while still in the service of that employer, and files same with the Bureau.

3. Report cessation of employment, whether engaged in profes-

sional work or not (forms are available).

Persons who have not changed employment since March 23, 1942, must register with the Wartime Bureau of Technical Personnel, but do not need to take any other action. Only when employment ceases must they report. The regulations apply to all persons who at any time have received the training or experience required to bring them within the classes mentioned above. Nor does the fact that a person may not be practising engineering or science at the present time exclude him or her from the effect of the regulations.

The question is sometimes raised as to what notice is required under the Technical Personnel regulations when a technical person proposes to leave employment. The actual length of notice to be given is not affected in any way by the regulations, but is set by the contract of employment which is about to be terminated. The notice period may vary according to the practice in the institution concerned and is sometimes included in a written contract of employment; in any case, it is a matter solely of common laws as between the two contracting parties.

What Every Employer Must Do

1. All employers must notify the Wartime Bureau of Technical Personnel of the cessation of employment of any employee in the categories specified (forms are available).

2. All employers must notify the Bureau of each specific need for technical personnel.

3. All employers must apply for permission to employ any person described in the regulations (forms are available).

4. All employers must secure a permit showing that their application has been passed on favourably before any employment contract can be completed (penalty of $500 for noncompliance).

Anyone wishing to engage a technical person in these categories should apply on Form TP-1 (white). This should be sent to the Director of the Wartime Bureau of Technical Personnel, Ottawa. If the information is sufficient, a letter will be taken as TP-1. Otherwise, blank forms will be sent to be filled in. Information is desired with respect to the nature of the work, the title of its position, the salary to be paid, the duration of the work, the qualifications required, etc.

When a technical person wishes to leave a hospital position, the employee should fill inTP-4 (pink) and the employer should use TP-3 (yellow). This should be sent to Ottawa. N.S.S. forms 120 or 208 should not be used for technical persons.

The regulations referred to above are known as Part III of Order-in-Council No. 246 (1943). A pamphlet explaining the regulations is available to those who wish to have copies. Copies of the pamphlet or any of the necessary forms may be obtained from the Wartime Bureau of Technical Personnel, 238 Sparks Street, Ottawa, or from regional representatives of the Bureau located in Halifax, Montreal, Toronto, Hamilton, Winnipeg or Vancouver, as well as from honorary representatives in Quebec City and Kingston.

Post-War Hospital Planning in Scotland

A COMMITTEE under Sir Hector Hetherington was appointed in 1942 by the Secretary of State for Scotland to consider post-war hospital problems in Scotland. Its report has recently been issued.

This committee was empowered to work out a programme of post-war development for a co-ordinated hospital service in Scotland on a regional basis, having in mind the future administration of new hospitals built by the Government; to work out means of securing the maximum co-operation between voluntary hospitals, the local authority hospitals and Government hospitals; and to work out financial arrangements between voluntary hospitals and local authorities and patients or contributors.

The committee is of the opinion that the present voluntary contributory schemes would not suffice to finance hospitals in the post-war period and recommends some form of compulsory, contributory insurance scheme, either as part of a comprehensive social security plan or as a purely hospital plan. There should be free institutional treatment available for all insured persons and their dependents.

Voluntary and local authority hospitals would receive payment from the funds at equal rates to cover approximately 60 per cent of the cost of services rendered. The balance would come either from taxes or from voluntary income, plus a direct exchequer contribution. In return for having their autonomy preserved, voluntary hospitals would be expected to raise a sixth of their annual cost of operation.

If a voluntary hospital cannot carry on under such an arrangement, it is proposed that statutory authority be given to the Secretary of State, after due inquiry, to order the transfer of the institution to the local authority.

Hospital facilities would be co-ordinated through regional boards, upon which the voluntary and local authority hospitals would be represented in equal numbers, together with an independent chairman and representatives of medical and medical-educational interests in the area.

It is suggested that the Department of Health include amongst its officers a small group of medical men well acquainted with hospitals and hospital administration and skilful in assessing the situation of the different institutions.

A national consultative council is not considered essential. National questions can be dealt with by special conferences summoned as required.

Some measure of uniformity in the financial relations between all general hospitals and their patients in a given area should exist.

Voluntary contributory schemes, although not adequate to finance the hospital system, might still remain in the picture for the provision of additional benefits.

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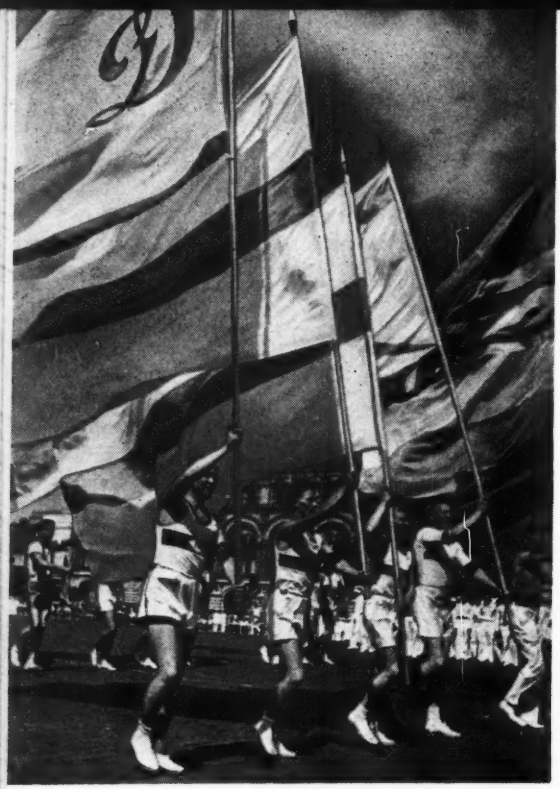


Physical Culture in the Soviet Union

PHYSICAL education has been developed on a much more comprehensive scale among the Russian people than has ever been attempted here. Undoubtedly the amazing programme of mass physical training of a whole generation has been a potent factor in the continued successes of the Russians under almost impossible conditions.

"Fizicheskaya kultura", or physical culture in a broader sense than conceived here, has been described by Percy M. Dawson in the autumn issue of the *American Review of Soviet Medicine*. A nation-wide "All-Union Council of Physical Culture" with a subordinate Council in each Soviet republic determines policies and directs the programme. Standards of efficiency have been set up and varying tests for those participating.

These tests are in three grades; one for children up to 18 years and two for adults. These are called BGTO and GTO (1st and 2nd degree). Established in 1931, by 1939 there were 5,729,000 men and women holding the first degree GTO; 67,000 held the second degree and over a million youngsters had won their BGTO. In all probability the number was still greater by the time of the outbreak of war in Russia in 1941.

Above—A parade of Soviet athletes.

The tests are of two types—obligatory and elective. Under the heading of "obligatory tests" we note sprinting and middle distance running, obstacle races, gymnastics, rope climbing, skiing (or walking), shooting, swimming with clothes on and carrying a rifle. Of importance from the viewpoint of spreading the doctrine, all candidates must show proficiency as propogandists and devotees of physical culture.

Under the heading of elective tests there are seven groups, including such items as acrobatics, basketball, bicycle racing, boxing, load carrying, chinning, fencing, gliding handball, hockey, hurdling, jumping of different types, jiu-jitsu, motor-cycling, mountaineering, parachuting, pole-vaulting, riding, rowing, running, ice-racing, shotputting, soccer, tennis, the throwing of various objects, water-polo and wrestling.

Under the heading of "riding" is listed "Circassian trick riding". A 300-metre course is to be traversed in 45 seconds, during which time the rider must jump down from his horse and up again six times for "pass" and eight times for "excellent" rating. There is also a series of vaulting gymnastics done upon the living horse within a definite time period.

The norms established for sex and age as a result of the checking of a large number of candidates are quite interesting. For example, in the 100-metre run, the time allowed for young women is 12 per cent longer than that allowed for young men, and is exactly equal to that of men over 41 years. In the 100-metre swim the norm for young women is 26 per cent lower than that of the young men, but again equal to that of the older men. Women are better high jumpers than they are long jumpers. The norm for young women in the long jump is 77 per cent that of the young men and 95 per cent that of the older men; but in the running high jump it is 83 per cent that of the young men and 11 per cent higher than that of the older men.

Training of Teachers

Teachers are trained in the institutes of physical culture, of which there are a number located in the large centres. These institutes are not considered as of secondary importance, but are reckoned among the

Right—Girl athletes parade through Red Square, Moscow.

schools for advanced study, such as the Pedagogic Institute, the Musical Academy, the medical schools, the universities, etc. Although some of them use laboratories, gymnasia and other facilities of other faculties or institutions, these institutes were being rapidly developed at the outbreak of war. Students are of several categories, being designated, for instance in Leningrad, as (1) regulars, (2) coaches, (3) dancers, (4) medical students, (5) sports doctors. Considerable research goes on in these institutes. The candidates for the courses as teachers are given very severe physical tests, and the curriculum is much like those in the schools of physical education on this continent. Subjects include not only those definitely related to the study of the human body and its performance in athletics, but include philosophy, history, political economy, foreign languages, music, drawing, mathematics and various military subjects. The students are paid better stipends as their work improves. The course is a serious one with long hours of practical and theoretical work. In the dormitory in Baku a posted schedule accounted for every hour of the 24, including seven for sleep.

It is interesting to note that chess may be substituted for one of the other activities. This is not unreasonable, for chess is the recreational analogue of military strategy. Also a student may specialize in research and may join the physiological staff of one of the institutes.

Sports Doctors

These activities have for their goal the improvement of the individual participant. Every effort is made to safeguard these participants from avoidable injury. The sports doctors who supervise the activities have what seems like unlimited authority. In the boxing contests only four or five rounds are permitted, and the sports doctors, who are not infrequently women, note the pulse rate between rounds and check up very closely on what seems like any major injury. If a contestant is knocked down he loses and the match is over.

Some 28 per cent of the students in these institutes for teachers are women. Certain of the activities are denied to women, but most of them are open to both sexes. They must understand all of the different games and exercises, however, for even though they may not box or wrestle, or lift weights, they may be called upon to teach these subjects to boys or to umpire contests between men.

It is of interest to note the facilities being developed in Russia for these athletic activities. A large number of club houses or stadia are being established, frequently with the aid of federal funds. Some of the stadia seat up to 50,000 to 60,000 persons. The projected stadia for Moscow and Kharkov were to have had a capacity of 120,000 and 100,000 persons respectively.

There are also children's stadia where juvenile competitions take place. These are carefully supervised to prevent critical injury to the participants.

Processions are characteristic of Soviet life. There may be as many as 60,000 sports men and women in the May Day procession, parading in gym suits. This in itself must be quite an ordeal, for Moscow has the latitude of Edmonton, Alberta, and these individuals must spend many hours waiting for the procession to start, and then waiting for their trucks to get them back home.

The parks in the Russian cities are very well equipped with ropes, bars, ladders, etc., and courts for tennis or basketball, pools for aquatics, and so on. Some of the parks are closed to adults all day and given over to the children and their instructors. A feature which we have not developed here is the setting up of towers from which people can make controlled parachute jumps. Altogether there are 600 of these towers in different cities, with queues of young people waiting for their turn. Mr. Dawson describes a number of intriguing pieces of equipment in his exhaustive article.

A feature of life in the Soviet Union to-day is that everybody takes exercise daily. This has become so indoctrinated into the younger generation that it is just accepted as the normal way of life for everyone. Even in factories the recess period is used for organized exercises.

Considerable importance is the practice of giving pregnant women exercises, beginning in the third month and continuing, under the doctor's supervision, even up to the onset of labour. Special booklets with photographs are available for the guidance of the women. Twenty-four hours after delivery the doctor supervises the first exercises of the puerperal woman. It is found that these exercises greatly reduce the need of cathartics and enemata, reduce the meteorism, hasten the involution of the uterus and improve the morale of the patient.

On leaving the hospital the patients are given directions for further

Above — Demonstration of Ciscassian trick riding.

Right — Parachute descent in a children's park, Moscow.

strengthening exercises and report back six months later for a check up.

Even the infants do not escape from these organized exercises. Nurses specialized in this work can begin these exercises when the child is but two and a half months old. They are continued until the infant becomes a nursery school child with a new set of exercises and games. It has been demonstrated that not only is bodily growth promoted but mental development improved as well.

The application of physical culture or exercises to those who are ill has been studied at some length. Exercise therapy and occupational therapy have been developed to a large extent in the military hospitals for the convalescent and slightly wounded soldiers. Observers agree that these procedures shorten the period of hospitalization and discharge the patient in a better physical condition than would otherwise be the case.

It would seem to be high time that we should give more concentrated thought to these developments in this country. It is unfortunate that over the years progress here has been so slow—except in British Columbia. The Dominion - Provincial Youth Training Programme showed what could be done, but only in a limited way. Apparently many of the provinces have been slow in taking up the federal offer of assistance.

However, we see definite signs of change. Three of our universities now have a faculty of physical education and are turning out thoroughly trained teachers in this subject. The Canadian Physical Education Association, backed by the Y.M.C.A. and the Y.W.C.A., has been stimulating interest in the subject for some years. The presentation of Dr. Ryerson, Dr. Lamb, Mr. Burridge and Captain Eisenhardt before the Special Committee on Social Security last May was an eye-opener. Now that the Physical Fitness Act has been passed, progress should be more rapid. It is hoped that this practical demonstration by our ally of what can be done on a large scale may stimulate nation-wide recognition of the importance of physical welfare.

"There are few callings in which there is so big a gap between routine and the best work as in medicine, and no profession needs to be so elastic in its government if it is to be dynamic, not static. Its front line of knowledge is always mobile and often advancing; the men working there need freedom for initiative and should be unfettered by the formulae of administration and, may be, on the other hand, by the demands of practice. And the same considerations hold in the sphere of clinical practice, for though we need ordered planning we must strive to avoid any cast-iron uniformity. Rather do we seek unity amidst diversity; for man, whatever his political colour, is individual, and in illness even more so than in health, and his doctor must remain an individual and not become an official. It is here that medical planning is up against its crucial difficulty, in that it requires collectivism for its fabric and individualism for human relationships. And individualism will not flourish easily within the rigid boundaries of a State service, but needs the freer atmosphere which belongs to the voluntary hospitals' tradition; for in the difficult conditions of a greatly changing world doctors will need not only knowledge but understanding if they are to guide bodies and minds along the straight road of health and content."

—Viscount Dawson of Penn, in B.M.J.

Purchases of Wartime Substitutes

Days of Inferior Supplies Numbered

By ERNEST A. DENCH,
Ho-ho-kus, New Jersey

THE hospital's purchasing agent has had to lower his professional standards since the war began. From sheer necessity, some of his purchases have been of the "pig in a poke" kind. He hoped they would all pan out for the best. Some did, while others proved bad buys. The only way to discover whether these wartime substitutes were any good was by experimentation. In some cases nothing else was available. He had to make snap decisions, aware that if he did not immediately grab the limited quantities offered, other buyers would.

His major concern was (and still is) to prevent interference with hospital maintenance and administrative efficiency. Whenever he could do so, he tried to purchase essential supplies a bit in excess of immediate needs. This carry-on spirit, while commendable, will from now on have to be tempered with caution. Large supplies of inferior wartime goods may prevent the hospital from using the genuine McCoys as soon as they reappear on the market.

The peak period for wartime substitutes has passed, and there is now a gradual easing of control. Production of some supplies for civilian use is being resumed in limited quantities.

No one knows exactly when the war will end. However, now that the United Nations are definitely on the offensive, the time has come for the hospital purchasing agent to give wartime supply substitutes a postwar buying analysis. Here are some questions and answers for consideration:

Is the wartime substitute item as good as the original it temporarily replaces? If it is, about the only sound reason for not buying too far ahead, apart from patriotic reasons and consideration for others, is the possibility of a price reduction when competitive conditions again prevail.

Does the substitute product deteriorate *faster* in storage than the one purchased in prewar days? If it does, no attempt should be made to build up a reserve, even if deliveries are irregular.

Is the wartime substitute a shoddy product selling at an inflated price? If it is, the present reserve stock should not be increased. Fill in at later dates, if necessary, with the smallest possible purchases consistent with safety.

Have there been complaints from the staff or patients about conditions arising from use of the substitute? If such is the case, the purchasing agent should start to look around for a worthwhile replacement item.

Is the substitute item one which the hospital would not use in normal times? If it is, buying should be confined to current needs.

Is the firm behind the substitute obviously of the unethical or fly-by-night type, out to cash in on the war emergency? If it is, the hospital purchasing agent should seek a product by a well-established house which will perform the same or a similar function. An advance order placed with such a firm will have postwar delivery priority.

Is the supply substitute packed in sizes, styles or grades contrary to hospital convenience or economy? If it is, a week-by-week re-order basis is advisable. Use of this product can then be discontinued once buying freedom is restored.

Are newly-established brands from the same producing sources as the old-timers trying to evade price ceilings? If they are, further purchases should be cut to the bare bones. At the first inkling of a buyer's market, the hospital manager or his puchasing agent should switch to the *other* firm which took care of its regular customers at legitimate prices. No purchasing agent could be expected to foresee *which* of the two firms would play the wartime game strictly according to Hoyle.

Is the hospital compelled to blend supply item "A" with supply item "B" in certain proportions, due to "A" being in short supply, and "B" very plentiful? If it is, "B" will either disappear from the market entirely or occupy a minor position when "A" is again in full flow.

Does the wartime substitute involve a lot of extra work, time and effort in the department or departments of the hospital where it is used? If it does, the department or departments so concerned will most certainly revert to the time-saving, easy-to-use original at the earliest feasible date.

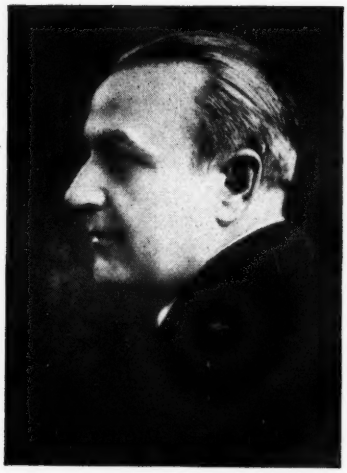
No hospital purchasing agent wants to be caught with what one member of his canny clan has dubbed "sub-normal" supplies. He wants his appropriations reasonably free and clear, in order to take advantage, as soon as they are available, of the following post-war opportunities:

1. The vast quantities of war salvage goods to be disposed of by the Dominion Government. These supplies will conform to the highest standards. Whatever method of disposal is chosen, there will be some exceptionally good buys in hospital equipment, medical supplies, machinery, etc., for spot cash.

2. The postwar models in hospital appliances and furnishings. Wartime scientific and medical discoveries converted to civilian use. New chemical preparations and processes. Radically different methods of building constructions. Even after allowing for exaggeration in some of the scraps of advance information given out, some of these war "babies" will bring hospitalization changes.

In conclusion, the prevailing seller's market for inferior supplies is an artificially-stimulated one. It needs close watching by the hospital manager or his purchasing agent to avoid a postwar hangover.

A Book Review



A Famous Surgeon Depicts Colourful Life

Dr. Max Thorek writes "A Surgeon's World" *

DURING the past few years medical reminiscences and settings have been popular, both in literature and on the screen. Undoubtedly this is due in large part to the unsually interesting experiences of so many physicians and, to no small extent, to the nature of these experiences. The most recent biography—"A Surgeon's World" by Dr. Max Thorek—is one of the most entertaining ones we have yet read, although we are not certain how much of this enthusiasm is due to the book itself and how much to our personal esteem and affection for the remarkable dynamo who has found time in an unusually hectic life to record the highlights of his already full career.

Son of a physician in a small Hungarian town, the youthful Max was brought to America when his family gave up everything to flee to a land where racial riots and strife could be forgotten. Those early days in Chicago, when the financing of the longed-for medical course seemed quite impossible, are well told, as is also the way in which he bluffed his way into obtaining free tuition. The university band needed a good snare drummer so badly that the university was prepared to offer the drummer part fees. Although an expert violinist, Thorek not only knew nothing about drums but retained a childhood horror of them. In desperation he said he could drum, and by claiming to be the best snare drummer in Chicago he succeeded in arranging for the cancellation, not of half his tuition fees but of all of them! To make good his claim he had to practise so incessantly on a hastily purchased second-hand drum that he was finally summoned to court as a disturber of the peace. That his drumming quickly became a feature of the band repertoire and his tuition assured was but to be expected.

Dr. Thorek's autobiography teems with anecdotes and reminiscences. Famous men and women flit across the pages and gripping dramas of hospital life with their incidents of pathos and of humour are recalled. No one knows the crises of domestic life as does the doctor—and generous-hearted Dr. Thorek interweaves these incidents into a philosophy of life which is most refreshing. Many crumbs of medical lore of both professional and public interest dot the pages; his chapter, "A Goodly Company", is a particularly fine review of the story of medical progress through the ages. To the purist in literature the text may be a bit disjointed and to the present-day blasé reader the tone may seem somewhat sentimental and at times even melo-

"Memoirs"
by
Max Thorek,
F.R.P.S., F.R.S.A.

"A Surgeon's World", by Max Thorek, M.D. Pp. 410. Price $4.75. Lippincott, 1948.

dramatic. Nevertheless anyone who realizes how this book must have been written in the midst of one of medicine's most crowded careers, and who knows the warm-hearted impulsive nature of its colourful author would not expect it, nor desire it, to be otherwise.

Some hint of this life is given in his book but it is only a hint. Seven days a week he is at the hospital by seven-thirty; the operating room and rounds take until noon; the afternoon is a frenzied flood of office consultations, telephone calls and professional visitors; then a quick round of the hospital, the precious dinner hour with the family, and back to the office, so profusely decorated with gift paintings, statuary and scores of his own "Grand Prix" and other trophies, and then back to his writing or his photography.

Few people realize his many facets of interest, although his autobiography gives intriguing glimpses. To his colleagues he is a brilliant surgeon, highly honoured for his technical achievements, author of an imposing array of surgical textbooks, secretary and a founder of the International College of Surgeons and editor of its journal. To devotees of the camera he is known as the man who has won possibly more awards in photography than any other person; his development of the paper negative technique led to the publication of the beautifully illustrated "Creative Camera Art". Known as the "musicians' friend", there is always a bed for sick musicians in the fine hospital of which he is chief surgeon and for which he is largely responsible. A member of the Chicago Business Men's Orchestra, Dr. Thorek still finds time to keep in touch with his many friends of the musical world, and has what is said to be the finest collection of autographs in existence. For those who have not had the privilege of knowing Max Thorek personally, his autobiography is an excellent alternative.

"Repulsed" by Max Thorek.

Manitoba Hospital Service Association Completes Five Successful Years

Canada's first Blue Cross Plan, the Manitoba Hospital Service Association, closed its books on the last day of 1943 with a total of 119,120 members (51,386 subscribers and 67,734 dependents). The financial statement shows a contingency reserve of $100,000 and a reserve for unreported and undischarged cases of $10,000, together with a surplus for the year of $49,807.

Income was spent as follows:

Operating expense	13.68%
Hospitalization	78.10%
Reserve	8.22%
	100.00%

Beginning on January 1st the Plan is offering a new family contract giving full coverage to family dependents, other than maternity cases, subject to the payment of $1.00 per day. The family rate is being increased from $1.00 to $1.25 a month. Concurrently with the adoption of this contract, members are to be furnished with additional benefits — gas anaesthesia and oxygen therapy, and payments to the hospitals are being raised to $5.00 per day.

The present enrolment, by the way, represents fully 16 per cent of the total population of Manitoba.

New Hospital for Sackville

The sum of $10,000 has been raised for equipment and a reserve fund to establish a hospital at Sackville, New Brunswick. An 8 or 10 bed maternity and emergency hospital is being set up on the second floor of the town's medical centre. If the experiment proves successful, it is hoped that it will develop into the establishing of a cottage hospital in a new building.

New Hospital for Huntingdon

On December 30th the Huntingdon County Hospital was officially opened by the Honourable Henri Groulx, Quebec Minister of Health. The hospital is equipped with twelve beds and eight bassinets in the nursery.

Obiter Dicta

Our Obligations Outside the Hospital

FOR some weeks now in one of our provinces a group of hospital administrators and trustees have been giving generously of their time and without stint in a committee study which will mean much to the hosiptals of their province, and, indirectly, to hospitals throughout the country. Simultaneously a committee of hospital accountants, already under strain to keep up with their own work, have willingly added to their burdens and have been toiling far into the night on a parallel study. The devotion and enthusiasm of these men and women could be duplicated from coast to coast, for in every province and state groups and committees are struggling with the never-ceasing task of working out solutions for the many problems confronting hospitals.

We owe much to these people who serve so conscientiously on committees or in executive office. In a young country like ours where we are spread out so thinly and where the many tasks must be borne by such a limited number, it is vital that those competent to bring judgment and experience to an assignment should be able to assume that responsibility. Over the years there has been a noticeable increase in the willingness of administrators and of directors of nursing and other departments to accept these tasks outside of the usual routine duties. There is an increasing realization that, if everyone does his or her part to effect joint effort, one's own hospital cannot but share in the advances made.

Sometimes there is a hesitancy on the part of administrators and others to so participate; and frequently this is due to a fear, and sometimes a clear realization, that the governing body expects the salaried officer to give undivided attention to his own job and not to spend time or energy on other undertakings, no matter how valuable to the hospital field. Fortunately instances of this nature are becoming rarer. Trustees are realizing that the time spent by their employees on such activities is not time lost but constitutes part of the contribution of their hospitals towards the improvement of hospitals in general. In the case of those hospitals with outstanding administrators, directors of nursing and other personnel, the contribution may be a heavy one—sometimes the presidency of an active association practically implies "leave of absence" for a period of time. This may put a heavy strain on others. Nevertheless it is realized, as Churchill so aptly stated last autumn, that "greatness brings responsibility", and great hospitals, or those with needed leaders in their midst, really have a moral obligation to share their good fortune with others. Trustees should be happy, and feel honoured, when representatives of their hospital are invited to make a reasonable contribution of service towards the welfare of all institutions.

Particularly pleasing is it to see the great assistance given by the trustees themselves, or by the physicians, the members of the women's auxiliary and other voluntary groups. To-day we are reaping the benefit of the grand foundations laid by those who have laboured in bygone years. What we do to-day—collectively and as individuals —will help our hospitals not only to-day but for years to come. At this very time, when so many fundamental issues are being determined, it is vital that every encouragement be given to the development of sound leadership and co-operative effort.

Amalgamation of Hospitals

UNDER the stimulus of wartime considerations, hospital leaders in Great Britain are giving much thought to the subject of amalgamation of hospitals. When preparations were being made to combat air attacks on London, much progress was made in bringing hospitals together and in effecting joint control and supervision of both voluntary and municipal hospitals. The question now before many hospital boards in Great Britain is, "To what extent would permanent amalgamation be advisable in the post-war years?" This subject was considered at some length in *Hospital and Nursing*

Home Management by Captain J. E. Stone, M.C., F.F.A.A., the well-known British hospital authority and author of several text books dealing with hospital administration.

Among the advantages of amalgamation which may be listed are: (a) more effective medical and nursing service to patients; (b) a better arrangement for training and maintaining a nursing staff; (c) elimination of waste and duplication in buildings and facilities; (d) saving in future capital expenditure; (e) greater financial strength, particularly during temporary financial stringencies; (f) more efficient administration, inasmuch as a larger number of hospital officers would be able to specialize in their work; (g) more effective publicity, particularly if an organized public relations programme could be developed; (h) more economical purchase of commodities.

On the other hand certain possible objections should be borne in mind: (a) it may not be desirable to carry on all work in one building and two sites may be necessary; (b) some loss of prestige to one of the constituent hospitals may be feared; (c) some of the staff and employees may lose out in the amalgamation agreeement; (d) if the various boards and committees are combined, the membership may become too big and cumbersome. However, Captain Stone feels that none of these objections are serious ones and all can be overcome with very little difficulty, if there be willingness on the part of the hospital authorities concerned to consider the subject from the angle of what is best in the interests of the public.

He agrees that amalgamation is not the cure to all the ills to which the voluntary hospitals are subject. "It does, however, fortify the hospitals concerned, and by strengthening their constitution and management, enables them to withstand the better the buffetings of modern conditions, and to provide for a more stable future."

Over the years quite a few amalgamations have taken place in Canada and these have been very effective. It is very doubtful, however, if conditions in Canada will require us to give as extensive consideration to the subject of amalgamation as has been desirable in Great Britain. For one thing our hospitals are much more widely scattered, geographically speaking, than they are in Great Britain and, with certain exceptions, few communities have more hospitals than they need. In Great Britain the problem is largely that of combining one voluntary hospital with another, or perhaps of combining a voluntary hospital with a municipal one. One fundamental difference between the hospital systems in the two countries is that we have here in Canada a much larger percentage of hospitals under the direction of religious organizations than they have in Great Britain. For this reason the objective to be desired here would more likely seem, in most instances, to be that of close co-operation rather than actual amalgamation. It is logical, however, to anticipate that the future may bring us a greater degree of affiliation between large urban hospitals and the small rural hospitals. Under the health plans now being projected, we may readily find certain patients referred from the rural hospital to the urban centre, either for diagnosis or for specialized treatment. Urban hospitals may tend to specialize in certain types of patient, and in that way some duplication of equipment and of personnel may be avoided. We may find scattered rural hospitals linked together with part-time personnel, such as travelling radiologists, pathologists, dietitians, etc., serving two or more of these hosiptals.

Hospitals and Inflation

COLD facts indicate that Canada has suffered less wartime inflation that any other nation. This is a record of which we can well be proud. However, those who are guarding Canada's financial welfare are much concerned lest certain factors looming up in the immediate future undo all the excellent work that has been accomplished to date. Pressure all along the line to raise wages and salaries not only means greater spending power for those getting the increases, thus resulting in deflection of material and workman-hours to less essential activities, but foments unrest among others who immediately want their incomes increased also. The net result is a spiral which, in corkscrew fashion, is insidiously breaking through the protective ceiling in countless places. For the large number of people on fixed salaries, now so materially reduced for practical purposes by taxation, and for those such as widows or retired people on fixed, and likewise reduced, incomes from insurance payments, annuities or pensions, the result of extensive inflation would be simply disastrous. Fortunately the rigid price controls, despite the machinations of some people to circumvent them, have accomplished much.

As every group and every individual can exert some influence on this situation, either of a stabilizing or of a disturbing nature, we in the hospital field can wield our share of influence. Hospital rates have been increased by most hospitals but only enough, as far as we know, to meet increased costs. Freedom to raise rates should not be abused and, we are sure, has not been abused. Medical charges have shown practically no change during the war period, a fact of considerable credit to the medical profession. Hospital wages and salaries have shown considerable increase, but such was long overdue and have not been unreasonable, although obviously influenced by the law of supply and demand. In view of the permanence and other desirable features of hospital employment, this inflationary tendency may soon become stabilized.

Some danger may exist with respect to the purchase of equipment. Certain types, off the civilian market for some time, are now becoming available again. Hospitals badly in need of replacements or trying to equip in order to meet expanded activities, are anxious to obtain this equipment, especially as many of them are showing better collections from paying patients than for many years. Equipment that is really needed should be purchased, if available, but hospitals can help the general situation by limiting these purchases to essential articles and postponing non-essential buying to a later time when their orders may be of real help in stabilizing the post-war period of re-adjustment.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Nursing in Great Britain

Dear Mr. Editor:

Lord Rushcliffe and his colleagues on the Committee, who were appointed two years ago to draw up agreed scales of salaries and emoluments for State Registered Nurses in hospitals and in the public health services, including the service of district nursing, and for student nurses in hospitals, are beginning to see the end of their labours. The principal outstanding item is to establish a uniform superannuation system. At present each local authority has its own arrangements and voluntary hospitals have a scheme of their own. The two vary in quite a number of points, so it is not being found an easy matter to reconcile them.

Hospital Nurses

On the whole the first report, which dealt with hospital nurses, has been brought into operation fairly smoothly. By offering to pay half the extra cost the Government secured its general adoption. Some people felt very strongly that the payment of student nurses from the day when they begin their training and the abolition of all fees, even for the preliminary training school, was a great mistake. Nursing cannot be said to be analagous to the training for professions open to women. However, that has been done and we can only await the result, not only upon the occupation, but also upon the type of attention given to the patients. In the meantime we have had a nation-wide campaign for more nurses, which has naturally led to a rather haphazard recruiting. Many of us believe that rates of pay, length of holiday, etc., are not the whole nor even the most serious items to be taken into consideration if we are to obtain an efficient and adequate nursing service. Every hospital committee ought to see the film which is drawing crowded houses at the present time. "The Lamp Still Burns" is based upon the book, *One Pair of Feet,* by Monica Dickens and shows the resentment against the petty rules which still prevail in hospital life. This week's (December 4th) *Lancet* has a leading article bearing upon the subject, of which the keynote is: "Nursing is as rigid a hierarchy as is to be found in democratic society . . . "Her's not to reason why" is still the general rather than the exceptional attitude forced on the probationer. As a result girls with individuality and initiative tend not to find their way into nursing, while those who do so lose something in their passage through the mill."

District and Public Health Nurses

In fixing the scales of salaries the Committee have taken into account the present cost of living and recommended the appropriate figures. The latest report, however, makes a departure in this connection by recommending an additional allowance for nurses working in the London area, as there is evidence that it is more expensive to live there than in other parts of the country.

A significant passage in the report, which is characteristic of the trend of thought at the present time, refers to the fact that most of the nurses covered by it are employed in preventive, not curative, health work. "This work," the Committee observe, "if less spectacular than the nursing of sick and injured patients, is of equal or perhaps even greater importance in maintaining the high standards of health which obtained in peacetime and which have successfully withstood four years of war."

In that connection the principal point to determine is the respective sphere of the public health visitor and the district nurse. In the urban areas there is room for both of them, though it is desirable to restrict as far as possible the number of people visiting in one household. In the rural areas there is not the work for the two officials and the district nurse has remarkable opportunities for doing work of an educational character, and possesses considerable influence in making it effective. The whole subject of the domiciliary nursing services was dealt with in a report recently published by a group of secretaries of District Nursing Associations. To it was added an admirable compartive review of the Canadian Home Nursing Service.

Comparison with Canada

The conclusion is so well balanced and authoritative that it will interest your readers for me to quote it *in extenso:*

"It would seem that the most outstanding difference between the British and Canadian systems is the broad Public Health Policy which has been carried out and gradually expanded from the inception of visiting nursing in Canada. The realization that health education is of the first importance is only now coming to the fore in Britain, where any rapid expansion of this policy in the District Nursing world is much more hampered than in the Dominion by the complexity and disjointedness of its own organization, red tape, traditions and the more conservative attitude of the public in general.

"The Victorian Order have achieved greater national and local co-ordination than in this country, not only within their own organization, but with other State, voluntary and commercial bodies engaged upon public health functions. Organizations contributing to the health of the community are regarded as inter-de-

(Concluded on page 56)

For Security

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Here and There

By The Editor

It Really Does Happen

A few mornings ago while driving down to his office, Mr. Chester Decker, well known general superintendent of the Toronto General Hospital, spied the telltale bag of a physician in the hand of its owner who was awaiting the bus. Faintly recognizing the doctor although not able to name him, Mr. Decker asked him if he would like a lift. The offer was gratefully accepted.

"Which hospital are you going to this morning?" he asked.

"Oh, I am going out first to the Air Force hospital. However, I am finding it a bit awkward to get there without several transfers."

After talking it over and deciding that it was about as awkward one way as another, Mr. Decker looked at his watch and said,

"Well, I am a bit early this morning and I hate to see you going to all that trouble. I'll tell you what—I'll just drive you over and save you all that bother!" His passenger protested vigorously but "Ches" being an ex-Boy Scout and now a good Rotarian was all for starting the day right and waived the weakening protests aside.

Mr. Decker had already realized that the doctor didn't recognize him so, as they slowed down at the other hospital, he said, "My name is Decker—C. J. Decker of the General Hospital. I am afraid I cannot recall your name, doctor."

"Oh, I am not a doctor," said his passenger alighting with his neat black bag, "I'm just the piano tuner!"

* * *

No Figurehead He

When the two hospital associations in Alberta decided to unite under the name "The Associated Hospitals of Alberta" and selected Mr. James Barnes of Calgary as the first president, the participating delegates chose very wisely. Mr. Barnes has sent to every hospital a 7-page presidential letter, in which he has reviewed a number of current subjects of vital concern to the hospitals.

This letter, dealing with the shortage of nurses, the maternity care legislation, health insurance, contracts, National Selective Service and other problems, contains much information of real interest to each hospital and should go a long way towards rousing and maintaining interest in the new Association.

* * *

How One Medical Discovery Was Made

The story of the discovery of the centre of speech in the brain is a strange one—and the discovery was made, not by a neurologist but by a surgeon!

A pauper lay dying of a gangrenous leg in the hospital of Bicêtre in Paris. That was back in the '60's. For twenty-one years old "Tan" had lain in the public ward suffering from a chronic neurological condition, and finally he had been transferred to the surgical service where he came under the care of a brilliant young surgeon of thirty-seven whose precocious mental development and amazing genius and skill had long since placed him at the head of his profession. But it was not "Tan's" gangrenous leg that interested him.

What really interested him was the story that, during his twenty-one years' sojourn in the hospital, following an epileptic seizure at thirty, the patient had been able to say but one word, *"tan!"* Day in and day out this cantankerous, bad-tempered patient had out-worn his welcome by his never-ending "tan's!" Perhaps his inability to say anything else made him that way. Ten years later various parts of his body began to show paralysis, but at the very beginning was this loss of speech. Could this case provide a clue as to whether or not the power of speech comes from some one part of the brain?

Realizing that the patient could live but a few days at the most, the young surgeon spent as much time as the patient's strength would permit examining and re-examining his nervous system. Seldom has a patient had such a thorough physical examination as did this patient. Six days later, Tan was dead and, within a few hours, the all-important brain was being examined. Realizing that the man could articulate, that he seemed to know what he wanted to say, and that he could understand the speech of others, it was obvious that the defect lay in the loss of power to initiate phonation. Careful dissection revealed, amidst more recent damage, an old scar in the third left frontal convolution. Although more cases were required to confirm and prove his theory, Paul Broca had set up another milestone in the history of medical progress.

At that time Broca was internationally famous by virtue of his surgical skill, his researches with the miscroscope, still in but limited use, and particularly for his contributions to the study of the cranium and other bones. Today he is best known to the student of medicine or nursing through "Broca's area" or "Broca's convolution". For years anatomists have been endeavouring to discourage the use of proper or personal names for anatomical structures and with strong justification, but the subject would lose much colour and romance if these links with the great leaders of the past were severed.

* * *

Mr. Abernethy, professor of anatomy and surgery at the Royal College of Physicians, and subsequently surgeon at St. Bartholomew's Hospital, many years ago, had an eccentric and rude manner which, curiously enough, increased his practice. A lady, who had scalded her arm,

(Concluded on page 56)

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Australia Studies Hospital and Other Requirements Under Social Security

IN view of the studies now being made in Canada to estimate our hospital and other needs under Health Insurance, a similar survey made in Australia in 1943 will be of interest. This study was made by a Medical Survey Committee appointed as a sub-committee of the parliamentary Joint Committee on Social Security, under the chairmanship of Dr. Alan B. Lilley, general superintendent of the Royal Prince Alfred Hospital, Sydney, who was a welcome visitor to Canada a few years ago. This Committee made an extensive visit of the various Australian states and tabled in Parliament an invaluable report of some 450 pages. A summary of the hospital needs is published in the September issue of "R.P.A.", the quarterly magazine published by the Royal Prince Alfred Hospital, one of the leading hospitals of Australia.

Prevalence of Sickness

From 2 to 3 per cent of the population are sick at any one time. This means that from 20 to 30 people in every thousand are in bed every day of the year.

Of these bed-ridden sick from 5 to 20 per cent need hospitalization, not including minor ailments and certain chronic diseases.

To apply the above rates to a population of 30,000 people means a bed-ridden illness of 600 to 900, that is to say a daily average of 750 cases of illness, of whom 10 per cent (i.e. 75) need hospitalization. This makes 2.5 per 1,000 of population. Authorities on this subject regard the provision of five general beds per 1,000 of population as necessary and sufficient to provide for a normal occupancy of 75 per cent of the beds, leaving a reserve of 25 per cent for expected fluctuations in the prevalence of disease. This standard doubles the requirement of 2.5 beds per thousand mentioned above, based on the prevalence of illness.

Owing to the greater fluctuation of demand in small population groups, a greater reserve of beds over those in constant use is required in rural hospital service than in cities.

Types of Beds Required

The following is the number of beds required for 1,000 of population:

General hospitals	5.0
Contagious diseases..	.5
Diseases of children..	.5
Maternity	1.0
Subacute diseases	.5
Convalescent patients	.5
Chronic diseases	1.0
	9.0
Mental diseases	4.5

Tuberculosis: Twice as many beds as average annual deaths from all forms of the disease over the last five years' period.

(Editorial Note: It should be noted that these figures are for the whole of Australia. In calculating for any one community in Canada we must consider varying conditions. For instance in a large urban centre it is safer to estimate six general beds per 1,000 and two beds per 1,000 for chronic diseases. Convalescent beds should be 10 per cent of the general beds. Tuberculosis authorities here take the viewpoint also that tuberculosis beds should be based on the diagnostic facilities and the number of cases discovered rather than the number of deaths. For that reason some of our authorities do not favour a bed-death formula.)

Application of Standards

Applying these standards to present facilities, it is noted that the present 57,660 general hospital beds now available are 6,690 short of the requirements for a population of over 7,000,000. Government and subsidized hospitals averaging 74 beds each provide 73 per cent of the total accommodation. Private hospitals averaging 14 beds each provide 27 per cent of the total beds.

"The Committee is of the opinion that it is impossible for the *smaller type of private hospital* to give efficient service in accordance with modern standards and still function as an economic unit. It can only continue to exist at the expense of service to the patient and there is overwhelming evidence that this is the case. Numerous examples can be quoted of a number of small, inefficient (from the point of view of service in accordance with modern standards), hospitals serving an area which could be much better served by a concentration of these facilities in one good unit. Each of these hospitals, with its administrative staff, operating theatre, delivery room, x-ray plant, kitchens, etc., is not working these services to economic capacity, and this, in our opinion, contributes to a great extent to the high cost of medical care."

Oddly enough, according to these standard requirements there is a surplus of 1,349 maternity beds. There is also a small surplus of children's beds and beds for infectious diseases. There is, however, a marked deficiency of beds for subacute and convalescent patients. Twelve hundred and thirty-four beds are available, and 7,150 are needed. As for chronic diseases there is a deficiency of 1,801, only one state—Victoria—having a surplus of beds for chronic diseases.

The linkage of beds for chronic diseases with homes for the aged and infirm is not a real solution to the problem, as chronic disease occurs at all ages. It is evident, therefore, that properly constructed, equipped and staffed special hospitals are needed.

Hospital Centres

The Committee recommends the setting up of community hospitals for private, intermediate and public patients with branches where needed. It is recommended that the hospital centres to be set up should include a well-equipped general hospital, an outpatient department and a pharmacy, with offices for physicians, dentists and technicians. All diagnostic and other facilities for the practice of modern scientific medicine should be available. In several country towns such an arrangement is now working efficiently.

Logical?

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* Bower, John O. et al.: *American Journal of Surgery*, 47:20, 1940.

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Unit System of Paying Hospitals

Arouses Discussion in Hospital Circles

THE "units of credit" system for the payment of hospitals, described in the November issue of *The Canadian Hospital* was reprinted as the lead article in *Hospitals,* the magazine published by the American Hospital Association, in its January number. With the article were published comments from a number of individuals to whom the article had been sent. The writer of the original article was then given an opportunity of replying to these comments in the February issue of *Hospitals.*

Comments had been requested of two strong supporters of the "cost basis" for paying hospitals, Mr. John Mannix of Detroit and Dr. A. C. Bachmeyer of Chicago. Mr. Mannix criticized the unit plan on the basis that it did not take into consideration variations in salary levels, variation in food and supply cost in different areas, variable hospital occupancy, the extent to which graduate and student nursing services are used, the tendency of patients requiring specialized treatment to go to the large medical centres, and the fact that some hospitals have a higher percentage of private or semi-private rooms.

With respect to these objections, the obvious answer is that the system does consider these points. Where a hospital is isolated, perhaps in a mountainous area, and food and supply costs are high, or where the patronage is so variable that special consideration must be given, it is stated in the proposed unit system that "for those hospitals in isolated areas, where supplies may be costly or where the patronage may be variable, thus adding to the per diem cost, allowance for special circumstances could be made by the proper authorities, by merely varying the monetary equivalent of the unit for such hospital; the estimation of points, however, should remain on the same basis for all hospitals." Higher salaries in cities would be compensated for by the higher average occupancy and by the various additional items for which larger hospitals receive credit.

As for the nursing, it has long been recognized that a properly equipped school of nurses with adequate personnel and with necessary affiliations is an item of definite cost to the hospital and can no longer be considered as providing cheap labour as in years gone by. Therefore units of credit have been assigned for an approved school of nursing and also for housing conditions for the nurses.

It is agreed that patients requiring specialized treatment tend to go to the large medical centres, thus increasing their cost of operation. This could hardly be considered a criticism of the units of credit method, for ample credits are given for the very items likely to apply only to the better-equipped hospitals receiving such demands for service, for instance deep therapy, a biochemist, a medical physiotherapist, an approved school for laboratory technicians, medical affiliation, blood bank, etc.

The fact that some hospitals have more private and semi-private beds than others does not affect the picture at all. This proposed system would be as a basis of payment for standard or general ward type of care. It is presumed, of course, that patients going private or semi-private would pay the difference in charges, thus adding to the income of the hospital with a large number of such beds. Under any general health insurance plan such a basis would probably prevail. Some organizations such as the Workmen's Compensation Board may stipulate semi-private care, and this may be stipulated also by plans for hospital care. In such cases the mill rate per unit of credit would be placed at a higher level than for public ward accommodation. That is very simple.

Mr. Mannix, in his comments, spoke very highly of the cost basis of payment, which he prefers. It has the advantage, he points out, of meeting full cost without profit. This would be fair to all hospitals. He does not think that it would require a more complex system of bookkeeping or of reporting than would be necessary under the unit system, nor does he feel that there would be very much difference of opinion in interpreting cost figures.

There is no doubt that the cost basis of paying hospitals has very distinct advantages. Most of us in the hospital field have urged its adoption from time to time; certainly it is infinitely fairer to the more fully equipped and staffed hospital than the flat rate basis of payment to all hospitals now prevailing in most provinces. Hospitals would be very happy if they could be paid on a cost basis for services rendered. It must be admitted, however, that the cost basis of payment has one very serious defect, a defect which will probably explain why it has been so seldom adopted, either in Canada or the United States. This defect is its inherent tendency to condone, and even subsidize, wasteful operation. We could state, as does Mr. Mannix, that efficiency and economy in hospital operation and administration are judged in the final analysis by the Board of Trustees, the medical staff and the public. That does not in any way mean that economical operation is going to be affected.

We have seen the extravagant results of the "cost-plus" basis of payment in war industry, and also in the construction of hospitals and other institutions where a contract has been let on a "cost-plus" basis. Hospitals themselves would favour the cost basis, but we might just as well recognize now as at a later time that governments, hospital plans, compensation boards and other bodies are not going to continue without question a

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Unit System

(Continued from page 40)

method of payment that is not conducive to economical operation. What the hospital field must do now is to find and develop a system of payment which closely approximates the actual cost for hospitals of different types and sizes but which puts emphasis upon economy rather than upon the reverse.

It is suggested that the cost basis could be controlled by establishing a fair maximum payment based upon the average cost of hospitals in the area furnishing comparable service. If that be done, then the system becomes no longer a payment of actual cost. Irritation develops, the incentive to improve service disappears and the hospitals desiring to give maximum service are held back by the others in the area giving cheaper service.

The suggestion that the unit system would be a more complicated procedure for the office than the cost basis cannot be accepted. Cost returns to authorities paying the funds would not need to be so elaborate (if required at all) and the accounting procedures need be only such as are required for the hospital's own information and that of the government.

Dr. Bachmeyer is of the opinion that too much emphasis is laid upon equipment and not enough upon the qualifications of the personnel. As stated in the original article, the values to be placed upon the different items can be subject to variations in the province adopting the plan, and the figures given are merely preliminary figures as a basis for further calculations. However, a careful study of the basis as outlined will reveal that many units of credit are given for expert personnel. For instance, 10 points are given for radiological equipment, but 20 for a full-time radiologist; 20 points are given for a pathologist and 15 for a biochemist. A certified technician draws twice as many points of credit as an uncertified technician. A.C.S. approval is given 10 points. The present basis does put emphasis upon expert personnel. Miss Jessie Turnbull of the Elizabeth Steel Magee Hospital in Pittsburgh suggests a higher unit rating for professional facilities and a lower rating for mechanical equipment. As stated above, that could be done very readily. The flexibility of the plan with respect to its ratings is one of its assets.

Mr. Lee S. Lanpher of Cleveland, Ohio, thinks the unit basis might be a reasonable approach where the problem of public funds is involved. He thinks that such authority might be assumed by the government, but would be hesitant to permit any private association to assume this responsibility over the payment to hospitals.

This brings up the question, who would list and evaluate the items? Certainly the hospital people are best qualified to select and evaluate items for credit, and therefore the provincial or state hospital association should have the major voice in unit apportionment. When it comes to determining the monetary payment, the payor rightly has some say; in such instances, however, the hospitals, through their associations, should have every opportunity to seek a satisfactory mill rate level. In other words the unit system does not introduce any complications with respect to payment or authority beyond what prevails at the present time. Actually, in any controversy with governments or other bodies the hospitals would have a more united position under a unit system, for all would gain by a mill-rate increase. At the present time with a flat-rate basis of payment some hospitals have little reason to complain, because their costs are fairly well met, if not overpaid in some cases, and therefore the high cost hospitals must bear the brunt of the struggle to get better payments.

Mr. E. A. VanSteenwyck, executive director of the Blue Cross Plan in Philadelphia, writes: "I had a chance last night to read your article on the "units of credit" system of paying hospitals. Thank you for a startling new idea which, I believe, holds the key to successfully adjusting some of the differences which are apparent in the ways hospitals are paid by Blue Cross and other agencies. Such a method of payment would, unquestionably, fit the community, the hospitals and the Blue Cross."

To quote from *Hospitals:* "It is questionable if there can ever be worked out a system to which some objection could not be taken. What we all desire is a system of payment that will be fair to all hospitals of varying facilities, that will stimulate improvement of those facilities and that will be fair to those providing the funds by inducing reasonable economies in operation. The units of credit system more closely approximates this ideal and presents fewer weaknesses than any other method of payment yet devised."

Bearers carry an Australian, wounded in the New Guinea fighting, back to an ambulance unit.

Courtesy Commonwealth Department of Information.

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Some Comments on Laboratory Technicians

From an address by Dr. Lall G. Montgomery, Chairman of the Board of the Registry of Medical Technologists, and pathologists at Ball Memorial Hospital, Muncie, Indiana. This address was delivered at the Indianapolis War Session of the American College of Surgeons. Dr. Montgomery is a graduate of the University of Manitoba and was for some time on the pathology staff of the Winnipeg General Hospital.

"SOME of the smaller hospitals are having to close their laboratories and x-ray departments for lack of technicians, and far too many hospitals are doing what is possibly worse than closing the departments, and that is, taking in poorly-trained technicians rather than do without. I am convinced that a poorly-trained technician is worse in some ways than none at all, especially in the pathology laboratory, and particularly in the small hospitals. The fact that the commercial technician schools and other unqualified agencies are using the war as a cloak for foisting their products on desperate hospitals and physicians and the public which they serve, is a particularly serious and dangerous situation.

"Another serious menace arises from the fact that the hospitals, by employing these unqualified 'graduates' of commercial technical schools and fly-by-night diploma mills are undermining the standards which have been set up by such national standardizing bodies as the Council on Medical Education and Hospitals of the American Medical Association, the Registry of Medical Technologists of the American Society of Clinical Pathologists, the American College of Surgeons, the American Hospital Association and the Catholic Hospital Association.* As a result, the schools approved for training are having difficulty filling their classes, which is further reducing the numbers of qualified technical personnel. The present problem is bad enough, but the post-war conditions will be still worse, and the hospitals and their patients will be the sufferers."

Dr. Montgomery advocated, to control the situation as far as possible, keeping the technicians which hospitals now have, which means paying higher salaries than in the past, saying:

"Losing a technician a couple of years ago was a nuisance but it is now a major catastrophe. . . . It usually costs less in actual salary to keep the original technician than to replace her and there is always loss of efficiency in making a change no matter how well qualified the new technician may be. A year ago in a study of the registered technologists of the country, I was able to show evidence to support the thesis that a national average salary increase of $200 a year would probably reduce very markedly the migratory tendencies of the medical laboratory technician. Anyone would be glad to do this now although it is probable that this figure would be greater at the present time. . . . In addition to establishing a salary level which will be conducive to stabilization, it is important to make the working conditions as pleasant as possible. . . . which is partly a problem for the medical staffs to work out because they are largely responsible for making the conditions. Elimination of unnecessary laboratory work is most important and particularly important is the care with which emergency work is ordered.

"Retired technicians may be persuaded to re-enter the laboratory. . .; if they do relief work for weekends, afternoons, or vacations, the regular technician's load will be so lessened that she will be content to remain. Another place where technicians may be found is in physicians' offices where they are wasting their talents acting as receptionists. . . . Many hospitals which have the necessary facilities do not have approved schools, and it is here that we can better ourselves by establishing training courses. Hospitals that have approved schools seldom lack for technicians because they always have the first choice of their own class. . . ."

*In addition, in Canada the Canadian Society of Laboratory Technologists and the Canadian Medical Association have co-operated to set up a high standard of qualification for memership in the C.S.L.T., which, by virtue of that standard, is looked upon as a registry of qualified technicians by the Canadian Medical Association.

False Hopes

We live in a world which is so cumbered with difficult problems that there is a tendency to look for short-cuts in everything, some easy panacea, some simple road to prosperity. We see it in politics where there are too many windy theories. We see it in economics where the fallacious short-cut has so many votaries. You have to fight the tendency in your own profession. There is always an inclination in the ordinary man to forsake science for what I might call magic. You have to fight the quack, just as the statesman has to fight the theorist, and the economist the charlatan. That is a humane and honourable duty. For *there is nothing more cruel than to mislead mankind by false hopes.* . . . The only hope for humanity does not lie in flashy short-cuts, but in a patient following of the path of clear thought and honest labour.

—*Viscount Tweedsmuir.*

$669,000 Mental Wing Started at Ste. Anne

Preliminary laying-out work has begun on the new four-storey mental infirmary building at the Ste. Anne de Bellevue Military Hospital in Quebec. It is being planned to accommodate from 300 to 400 cases of mental war injuries, and will be a completely self-contained unit, with heating, refrigeration, kitchen storage and other facilities separate from the rest of the hospital.

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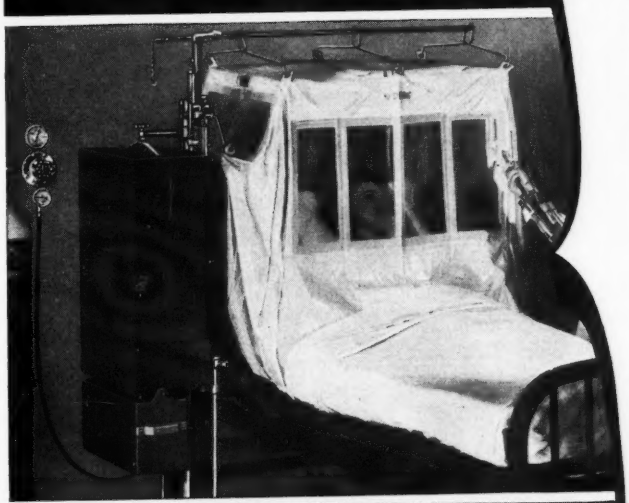

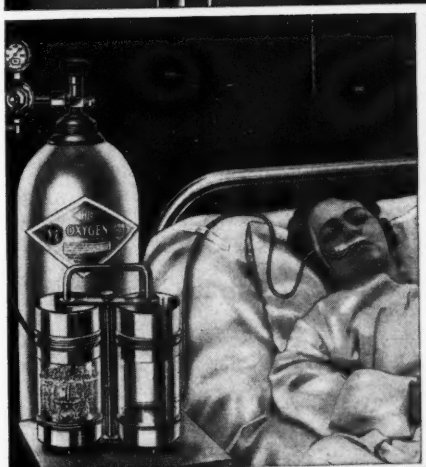

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Control Board Rulings

Income Tax Deductions

Following a request from one of the member associations, the Canadian Hospital Council has been in communication with the Department of National Revenue with respect to deductions on income tax payments for donations to hospitals. Mr. C. F. Elliott, Deputy Minister (Taxation) has replied to our questions as follows:

Question: Do civilians obtain credit on income for gifts to hospitals either for hospital services or for facilities and buildings?

What percentage of income can be applied to such charitable donations?

Answer: An individual is entitled to claim as a deduction against his income amounts given by donations to a hospital if such hospital is recognized as a charitable organization in Canada. However, payments for services at the hospital are not allowed insofar as they may be part of the medical expenses incurred and so allowed as a deduction within the limits provided for in Section 5 (1) (n) of the Income War Tax Act. The amount which will be allowed as charitable donations must not in the case of individuals exceed 10% of the taxable income.

The amount which will be allowed in respect of medical expenses includes both hospital and doctors' fees and is the amount expended in excess of 5% of the income of the taxpayer, but the deduction shall not exceed the sum of four hundred dollars in the case of a single person and six hundred dollars in the case of a married person, plus one hundred dollars for each dependent of the taxpayer.

Question: Do firms and incorporated companies have the same privilege of tax exemption for charitable purposes as applied to individuals?

Can any special permission be obtained whereby excess profits can be partially used to assist hospitals?

Answer: Corporations are also entitled to claim as a deduction amounts donated to charitable organizations in Canada but the extent of the total charitable donations claimed in any one year must not exceed 5% of the income of such corporation. No special permission is required insofar as this Department is concerned. The relief is granted under the terms of the law itself, being Section 5 (jj) of the Act.

Question: Many employees now belong to group hospitalization plans and in many instances the employer contributes towards the payment of premiums. In the United States a ruling has been made that the premiums paid by employers represent ordinary and necessary business expenses which are deductible. Also where an employer is not obliged to furnish hospitalization, or to pay for hospitalization, under a contract of employment, any premiums paid by him on policies of group hospitalization insurance covering his employees and their dependents are not required to be included in the federal income tax returns of the employees.

Can you inform us if any similar ruling exists in Canada or would you be in a position to make a somewhat similar interpretation?

Answer: There is no authority under the Income War Tax Act whereby the contributions of employers toward the payment of sickness and hospitalization plans for employees can be recognized. Therefore, such a ruling as has been issued in the United States and referred to by you is not possible under the present law.

* * *

Importation of Textiles Permitted

For some little time back the importation into Canada from countries outside the sterling area of certain textile products such as sheets, blankets, pillowcases, diapers, towels and wash cloths has been prohibited under Part 1 of Schedule 1 to the War Exchange Conservation Act, 1940.

By an Order-in-Council dated December 24th, 1943, (P.C. 9774) the importation of such cotton products or articles under permit is allowed.

"In order that applications for permits for the importation of the sheets, blankets, pillowcases, diapers, towels and wash cloths now included in Part 2 of Schedule 1 may be dealt with as expeditiously as possible, applications, in duplicate, must be made on the prescribed form, which, together with all correspondence relating thereto, should be sent direct to the Cotton Administrator, Wartime Prices and Trade Board, Aldred Building, Montreal, Que. The form to be used is the "Application for Permit to Import War Materials and Other Goods" and supplies thereof may be obtained from Collectors of Customs and Excise or from the Department of National Revenue, Ottawa.

"It should be stated on the application whether the quantity for which permit is requested will be imported in one or more than one shipment." (WM No. 35 (Revised) Supplement No. 10).

* * *

Jelly Powders

With regard to the efforts being made by the Canadian Hospital Council to secure larger supplies of jelly powders and gelatine for use in hospitals, we have received the following letter from the Wartime Prices and Trade Board:

"Dear Dr. Agnew:

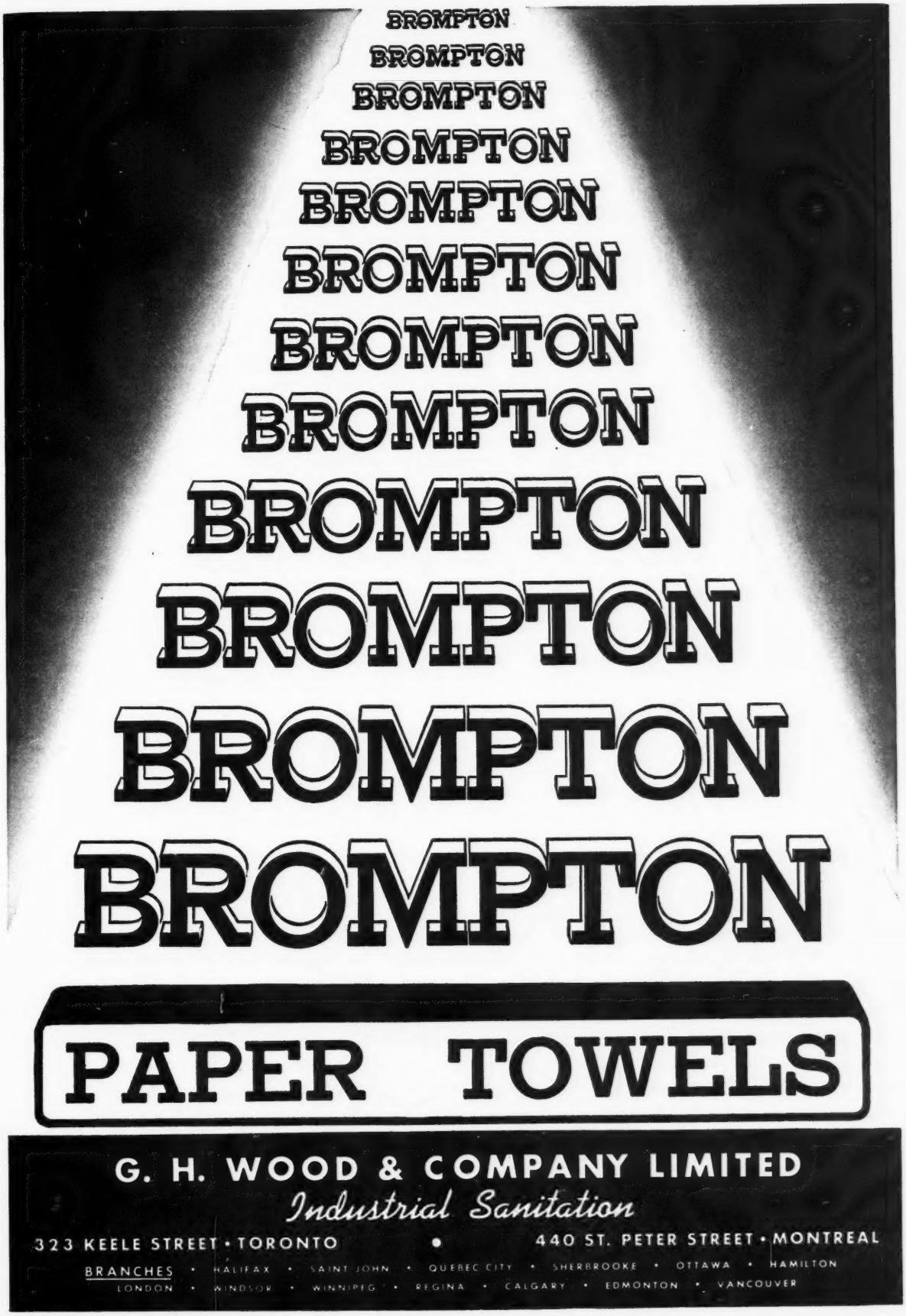
"Further to previous correspondence from Foods Administration with you concerning jelly powders for use in hospitals, would it be possible through your Council to be informed of instances where, and to what extent, hospitals are unable to be ratably supplied by their wholesalers with jelly powders, according to their 1941 usage?

"You will recall that an earlier communication pointed out that although a system of priorities for jelly powders had not been established, wholesalers would be requested to furnish hospitals with a ratable supply based on 1941 usage.

"Any information that you can pass on to us of the existing conditions in hospitals respecting this product will be welcome, and your co-operation in this matter will be greatly appreciated.

Yours very truly,
"Marjorie L. Scott",
Assistant to Nutritionist, Foods Administration."

Hospitals which have experienced difficulty in obtaining an adequate quota of jelly powders are asked to write, giving full particulars, to the Canadian Hospital Council or directly to the Foods Administration at Ottawa.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Correspondence

T.B. and Health Insurance

Dr. Harvey Agnew,
Secretary,
Canadian Hospital Council,

Dear Dr. Agnew:

On looking over the proposed draft of the Health Insurance Bill being advanced by the Dominion Government I was somewhat disconcerted to find that hospitalization of tuberculosis was not included. It occurred to me that you might have at hand information as to the reasons for excluding hospitalization of tuberculosis.

Yours very truly,
"Donald M. Cox",
Secretary and Manager,
Winnipeg Municipal Hospitals.

Reply

Dear Mr. Cox:

In the hospital benefit section of the Model Provincial Act it is stated that hospitalization shall be for qualified persons but shall be for "other than hospital services for tuberculosis or mental illnesses (except as may otherwise be prescribed)."

However, the reason for this apparent exclusion of tuberculosis would seem to be because it is presumed that the tuberculosis patients will be cared for under a special arrangement and not be included under any general health insurance plan wherein the individual would pay part of the cost.

In what is called the First Schedule of the proposed measure the federal government is prepared to make grants to the provinces for specific purposes, provided they in turn conform to the Model Provincial Act outlined in the Bill and undertake certain prescribed activities. This so-called First Schedule outlines the different grants to be made by the federal government to the provinces. The first one is, of course, for the general health insurance measure; the second item on this list is for tuberculosis grants and "treatment" is added in brackets. It is here stated that the object of the grant is "to provide free treatment for all persons suffering from tuberculosis, including the provision of additional buildings and bed accommodation". It is stipulated that the province is to provide free treatment for all persons resident in the province suffering from tuberculosis to the satisfaction of the Governor-in-Council. The annual amount of the grant is to be a certain proportion (as yet undertermined) of the moneys expended by the province for the free treatment of persons suffering from tuberculosis, including capital expenditure.

* * *

Credit for Nursing Service

Dear Dr. Agnew:

I have been studying with considerable interest and some alarm the proposed plan for a unit of credit system as a method of paying hospitals. Am I correct in my interpretation that out of a total of 350 units the number set aside for nursing ser-

(Concluded on page 50)

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1 Romberger, Floyd T.: *J. Indiana S. M. A.* 35:613 (Nov.) 1942.

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Correspondence

(Concluded from page 48)

vice is 15? That is, if the cost per patient per day were $3.50, only fifteen cents would be allowed for nursing (including the cost of the school). Recent figures indicate that the cost for nursing per patient day ranges from .55 to $1.24.

Yours sincerely,

————, Reg. N.,
Superintendent of Nurses.

Reply

If you will read carefully the article in the November issue of *The Canadian Hospital* you will realize that nursing care is fully covered. The 350 points which you mention are the basic units of credit only. These are given for basic care common to all hospitals and include general nursing, food, heating, administration, etc. The fifteen points which you mention are additional credits which would be given for certain features relating to nursing, that is to say an approved school for nurses and a better type of residence.

Whether or not the basic figures are adequate, or whether credit should be given for additional details, such as the percentage of graduate nurses per so many patients, are details which would need to be adjusted in any province adopting the plan. If the principle be adopted that hospitals should be paid upon the basis of the extent to which various facilities and improvements are provided, the selection and adjustment of details can be readily effected.—G.H.A.

New Hospital Head Takes Over Duties

Dr. Leigh J. Crozier, took over his new duties as superintendent of the Victoria Hospital, London, on February 1st. Dr. Crozier, who is a graduate of McGill University, conducted a large medical and surgical practice in Chapleau, Ontario, for many years. He was also medical health officer and head of a large industrial hospitalization project. The vacancy was created by the resignation of Dr. L. C. Fallis, who is now with the Ontario Department of Health.

The nation's health is the nation's greatest asset in war as well as in peace.—*Hon. Maury Maverick.*

Saint John General Hospital Appoints New Superintendent

The resignation of Dr. S. R. D. Hewitt as superintendent of the Saint John General Hospital was accepted with regret by the board of commissioners. Mr. Ralph H. Gale, who has been acting superintendent while Dr. Hewitt was on leave of absence because of ill health, was appointed new superintendent. Mr. Gale took over his new duties on January 1st. He served as assistant superintendent under Dr. Hewitt.

Dr. C. S. Tennant Joins Health Department Staff

Dr. C. S. Tennant, superintendent of the Ontario Hospital, Brockville, for the past ten years, resigned his position on December 31st and is now with the Ontario Department of Health in Toronto. Dr. Tennant's successor is Dr. Charles E. Hanna of Delta and Penetanguishene.

You cannot prevent the birds of sorrow from flying over your head but you can prevent them from nesting in your hair.—*Chinese Proverb.*

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Soviet Russia's Medical Services Described by Dr. Sigerist

"THE transition from peace to war medicine was in many ways easier for Russia than for other countries, because medicine there was already organized and prepared for a sudden change-over to war conditions", Dr. Henry E. Sigerist, professor of the history of medicine at Johns Hopkins University, told his audience at the seventh annual conference of CAMSI.

"The medical miracles we are applauding to-day are not brilliant improvisation, but the result of years of planning. Russia knew she would be attacked, and she prepared accordingly. Her civilian defence corps, for instance, was organized in the early 'twenties. For years all medical students had been trained as army physicians. She had twenty-six scientific research institutes (the equivalent of our National Research Council) devoted to the different branches of medicine. She had no need of a Procurement and Assignment Board, because her doctors had always been distributed on a basis of need. The fact that Russian medicine has stood up so well argues a very good organization behind it. The mortality of Russian wounded is only one-half of one per cent, and about 73 per cent of the wounded are rehabilitated."

In Russia medicine is a public service to which everybody is entitled as a constitutional right, just like education. All health services are organized under the Commissar of Health, whose responsibilities and powers are far greater than those of the Minister of Health in other countries. He controls not only all public health services but the equipment and personnel necessary to carry them out. Medical, nursing, dental and pharmaceutical services come under his jurisdiction.

"The positive goal of perfect health is held before the people. Health precepts are taught everywhere in the language of the people. Good health is considered to be the duty of all good citizens, and thus health education is linked with social and political education."

One very successful experiment has been the great programme of physical culture under medical supervision, in which all who are fit are expected to take part. The Russians are proud to wear the badges which testify that they have completed the rigorous training. (See *Physical Culture in the Soviet Union* elsewhere in this issue.)

Proper rest and recreation play an important part in the Soviet health programme. Organized recreational camps for holidays, and recreational facilities in factories, folk-dancing groups, etc., all contribute to the enjoyment and health of the workers. Wherever people come together in work or social life, a health committee is set up and the entire group takes part in planning health projects. The direction of the work is centralized, but the committees are decentralized as much as possible,

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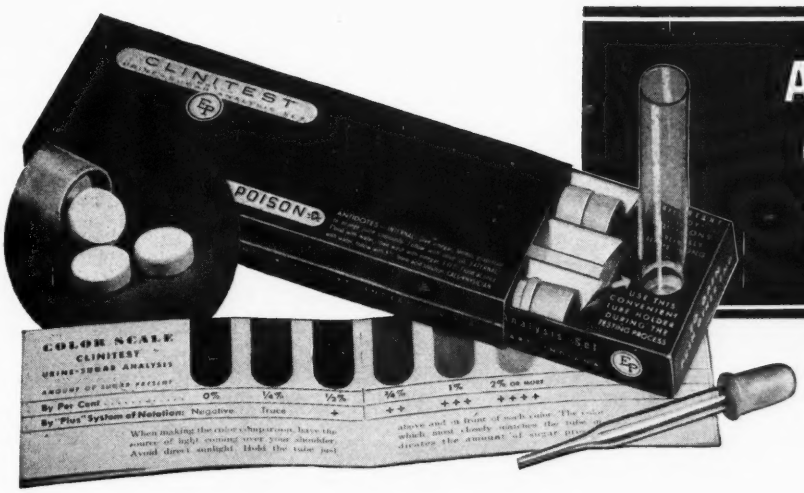

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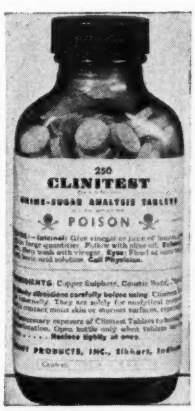

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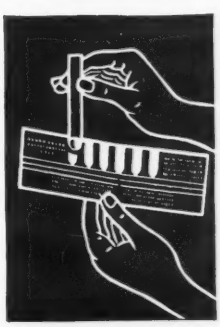

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Soviet Medical System Described by Sigerist

(Continued from page 52)

and the whole scheme is worked out along democratic lines. The health budget has increased steadily, and even in the days when the war was threatening, neither the health nor the education budgets were cut.

Medical centres have been developed extensively. There are 13,600 fully equipped centres in the cities and 14,000 in the rural centres. They make the best use of medical knowledge and keep as up-to-date as possible, though the very serious cases go to a district hospital which serves a number of such medical centres.

A centre to look after 750 people would probably have 12 beds and 6 maternity beds, and might be served by a physician, a surgeon, a dentist, 2 midwives and 2 nurses.

The rehabilitation of the sick and injured is considered very important. Every effort is made to keep a man from dropping from the skilled to the unskilled labour class by reason of physical disability. Special factories are available for those who are physically handicapped, where the work is adjusted to their capabilities.

The speaker urged a closer rapprochement between Russia and the rest of the United Nations in the exchange of medical and hospital knowledge. A beginning has already been made through the Anglo-Soviet Medical Committee and the American-Soviet Medical Society, which translate and exchange papers on the latest medical advances of the different countries. After the war it is hoped to set up an exchange of post-graduate students, professors and physicians.

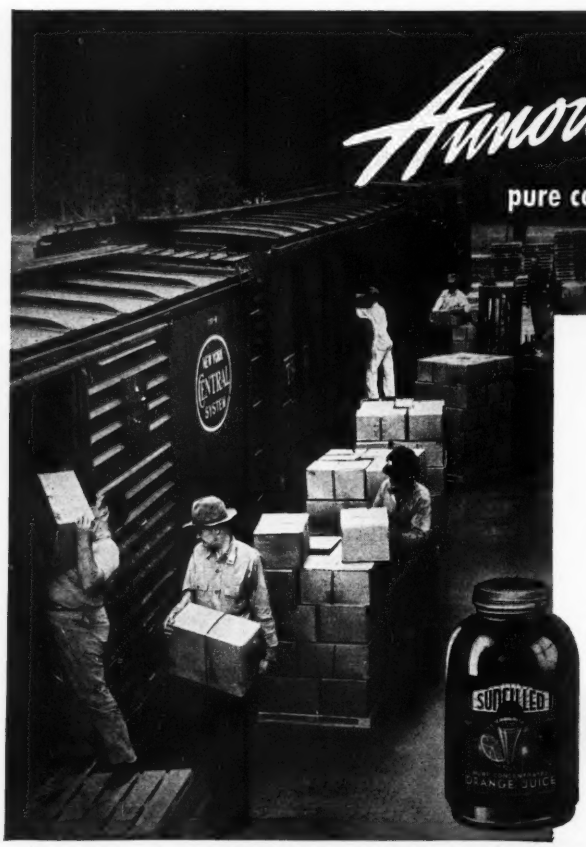
"There is no doubt that the voluntary hospitals themselves are guilty of having committed partial suicide through their own failure to realize the signs of the times. For example, they have erred foolishly in upholding to an extreme limit their individuality, their independence, their contempt for the public health organizations, their refusal either to co-operate among themselves or with the health authorities, state and municipal; and now when it is too late their death bed repentance is not evoking much sympathy from the state or the municipality."

—Sir Frederick Menzies, M.D., reprinted from "Medical Care".

Price Trends

(On basis 1926 = 100)

	Yearly Average 1942	Dec. 1942	Nov. 1943	Dec. 1943
Building and Construction Material	115.2	116.7	126.1	126.5
Consumers' Goods (Wholesale)	95.6	97.1	97.4	97.8
	(On basis 1935-1939=100)			
Cost of Living	117.0	118.8	119.4	119.3



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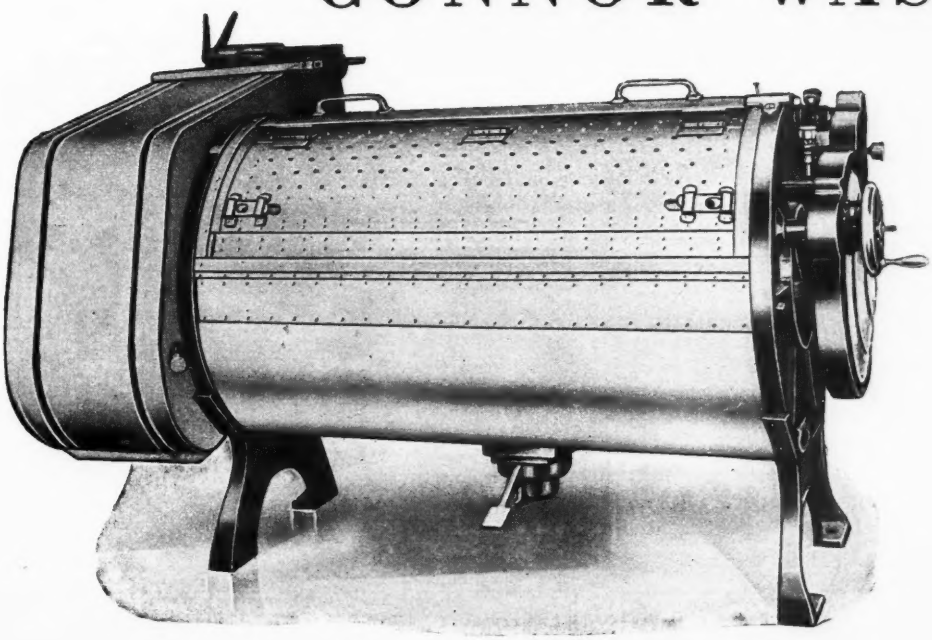

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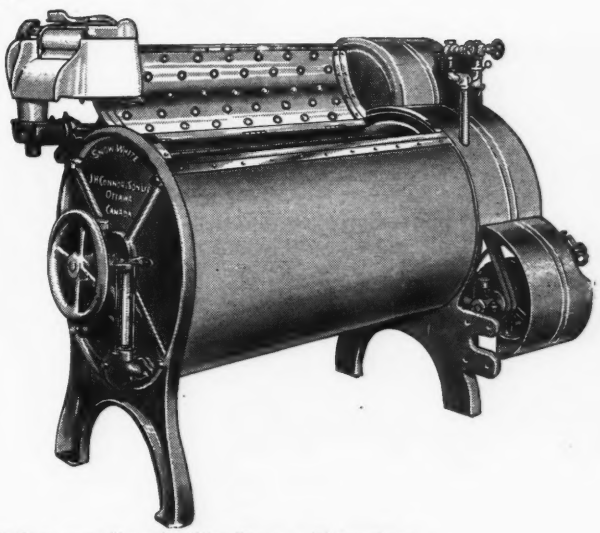

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Planning in Scotland

(Concluded from page 25)

The principle of payment to the hospital should be one related to the services rendered or capable of being rendered by any particular hospital. Different rates of payment should be made to hospitals providing different standards of service, and it is recommended that hospitals be classified in three categories, with a super-category for hospitals providing particularly expensive service.

Grants from local health authorities would be regulated by an established standard rate of expenditure for hospitals of different types. The standard cost of services in hospitals of particular types should be ascertained possibly on the basis of five-yearly surveys. In the case of voluntary hospitals the local authority grant should be such that a proportion of strictly charitable or voluntary income should be left for development.

The treatment of infectious diseases, tuberculosis and mental diseases would seem to be left in large part to the local authorities. Apparently the treatment of these diseases is not to be brought within the national hospital plan.

Regional councils, among other duties, would participate in the appointment of medical staffs to hospitals. It is recommended that the governing bodies of hospitals should be advised of the filling of, at any rate, senior medical appointments by a regional appointment committee.

With Hospitals in Britain

(Concluded from page 34)

pendent parts of one public health service. This is true, not only from the medical standpoint, but also from that of administration and finance, as witness the growing appreciation in Canada of the "Community Chest" idea. In theory the principle of community service is realized in Great Britain, but in practice the separate health organizations, District Nursing among them, tend to remain isolated, with the result that competition for status and finance diminish the "service to health" of the whole."

The conclusion of the report also refers to the greater freedom allowed to nurses, and hours of duty being arranged so as to make it easier for them to enter into social and recreational pursuits when off duty. It may be that if other sections of the nursing world showed the same readiness to learn from others, and especially from the Dominion, the outlook for the future might be more promising.

Here and There

(Concluded from page 36)

called at the usual hour to show it to him on three successive days. The following conversation is said to have taken place. First day—Patient exposing the arm says: "Burnt". Abernethy: "I see it". Prescribing a lotion she departs. Second day—Patient shows the arms and says: "Better". Abernethy: "I know it". Third day—Patient showing the arm once more says: "Well". Abernethy: "Any fool can tell that. What d'ye come again for? Get away!"

—H. A. J. Lamb in "Hospital and Nursing Home Management."

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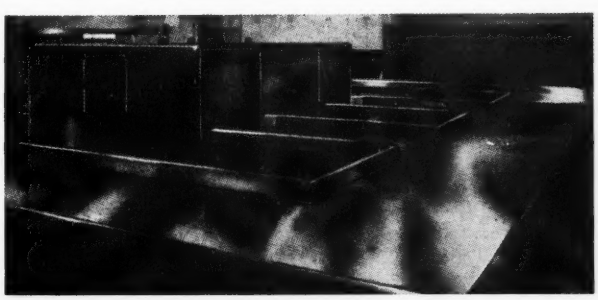

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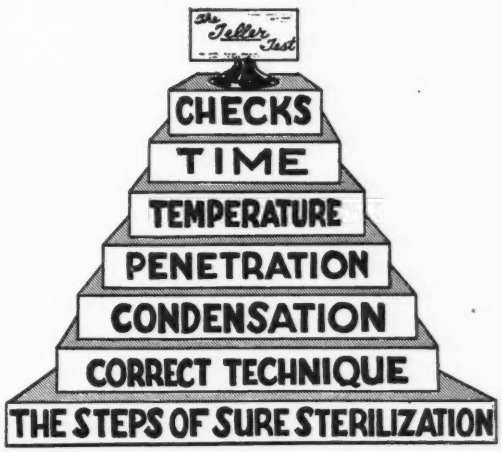

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Protecting General Staff of T.B. Hospital

(Concluded from page 22)

slight illness. If the first I.C. test is negative, we try to put them on wards where there is little infection. The test is repeated every three months until a positive reaction is obtained. When the I.C. becomes positive, the employee is placed on wards with minimum chances of infection, such as the babies', the children's or the bone and joint surgical wards, until such time as they overcome the initial infection. During this period they are x-rayed every three months to make sure that the infection is not developing; they are advised to take all rest possible. Physical and blood examinations, including cell sedimentation rates, are done whenever indicated.

Employees are warned to keep their hands from their faces and hair or, if they must touch these, to wash their hands first. They (and this includes physicians) are asked to change their outer uniforms or clothing before going to meals and to wash their hands thoroughly and their faces.

We have recognized for a long time that our hospital personnel must, in addition to being kept healthy, have good food and living quarters; to this end we have provided large, cheery, clean residences and rooms where they can spend their spare time or entertain their friends. The food is good and well prepared. We try to make conditions as homelike as possible. With the great scarcity of help it is difficult to have all these things done as well as we would like, but we are satisfied that, if all our instruction and rules are put in full force, tuberculosis should not develop in any staff member or employee.

The average stay in a hospital is 10 days, but patients under the Hospital Plan come out in 8 days. When the doctor says "Hospital" they can go at once instead of waiting to save or borrow the money, and they go with never a worry about debt. No wonder they get well quickly.—*Farmers' Advocate.*

Protecting Nursing Staff of a T.B. Hospital

(Concluded from page 23)

of them is a health teacher and that their work as teachers is as important to the patient as nursing him back to health. We aim also to make the patient realize that tuberculosis is preventable and that this knowledge has placed a great responsibility on him.

Special attention is paid to the health of the employee.

One day off each week is given in order to prevent exhaustion.

Mrs. Alton Goldbloom Re-elected President

At the eighth annual meeting of the Women's Auxiliary of the Jewish General Hospital, Montreal, Mrs. Alton Goldbloom was re-elected president. In her report Mrs. Goldbloom stressed the necessity of "building up finances to meet the coming of a better day". The Women's Auxiliary expended a total of $10,111.00 last year in giving aid to the hospital.

GUARANTEED* to get rid of ROACHES -or your money back!

Saphelle POWDER (P.C.P. Act. 82).

EASY TO APPLY—Fold paper or cardboard in "V"—sprinkle line of Saphelle along wall bases, mouldings, window and door frames and in all cupboards.

ACTIVE FOR WEEKS — Leave powder exposed for three to four weeks, then repeat application. (Or if you wish, make more frequent applications for shorter periods.)

*If, after two applications, satisfactory results have not been obtained, return the balance of the package to us and we will refund the *full purchase price.*

A SAPHO PRODUCT

Made by the makers of Sapho Liquid, Sapho Liquid Odourless, Sapho Powder and Saphine. Saphelle is sold in 50-lb., 100-lb. and 250-lb. quantities.

The Kennedy Manufacturing Co.
112 McGill Street MONTREAL

QUEBEC OTTAWA TORONTO WINNIPEG VANCOUVER

Hospitals of Any Size
can purchase
requirements of
Standard Record Forms
at economical quantity
production prices . . . .

WRITE FOR SAMPLES AND PRICE LIST.

Hanger Cards
7¼ by 4½ inches
punched, corded; choice
of brown, blue or green.

These titles in stock
"Treatment Being Given"
"Silence Please"
"Patient Sleeping"
"No Visitors Please"

Special cards, one or a dozen or more made to order by our Embosograf process; choice of several color combinations; ask for quotations.

HOSPITAL & MEDICAL RECORDS COMPANY
175 Jarvis Street - - Toronto, Canada

Cereal Found to Be a Reliable Source of Crude Fibre Content!

Wide variations found in the digestibility of fibre from other nutritional sources!

TO test whether theoretically equalized amounts of fibre from various food sources would produce equal laxative results, experiments were conducted in a Midwestern U.S. university using a group of advanced chemistry students.* These subjects were put on a control diet from which crude fibre had been removed. Foods, containing "equalized" amounts of crude fibre, measured according to tables in nutrition textbooks, were then added, and laxative effects compared.

Slight variations were noted from individual to individual, as was expected. But wide variations appeared in the relative digestibility of crude fibre from the various nutritional sources.

The fibre sources shown to be most effective in their action were cabbage and KELLOGG'S ALL-BRAN. These showed pronounced "bulk-forming" properties and satisfactory laxative action. The fruits and other vegetables studied gave variable and less pronounced effects.

It can thus be seen that KELLOGG'S ALL-BRAN, a uniformly prepared cereal, with a practically constant crude fibre content, will be reliable in its desirable laxative "bulk-forming" effect.

*Full reports of experiments available to doctors and others interested on request to:

KELLOGG COMPANY OF CANADA LIMITED, London, Ont.

When Ordering Your Supplies from Stafford's . . . Ask for a Share of the Limited Quantity of . . .

STAFFORD'S BASIC

JELLY POWDER

- It's a NEW product.
- It's different . . . It's delicious.
- A little goes a long way.
- True-fruit flavour.

EMPHASIS is being laid upon the importance of basic jelly powder in hospital dietaries. Stafford's are filling this need within limits of existing conditions. Our fair methods of allocating available stocks will entitle you to a share of Stafford's rich, delicious jelly base along with your order of other Stafford's food products made up especially for hospital use. Stafford's NEW basic jelly powder is easier to make . . . has the true flavor of raspberry, wild cherry, strawberry, orange, lemon and lime.

For something different in desserts, serve Staflex Custard Powders in a variety of popular flavors. BAKER'S CONCRETE FLAVORS . . . for flavoring bake goods, syrups, sauces, meats and soups. Try the NEW Karmella flavor.

J. H. STAFFORD INDUSTRIES
LIMITED, TORONTO

Order-in-Council Protects M.O.'s in Reporting of V.D. Cases

An Order-in-Council made public on January 26 gives protection to medical officers of the armed forces in Canada and commanding and medical officers of visiting or foreign forces stationed in or travelling through Canada against actions for damages arising out of the reporting of cases of venereal disease diagnosed or treated by them.

Several of the provinces have statutes requiring physicians to report cases of V.D. which they diagnose or treat to the provincial health authorities.

Trustee Analyzes Job

(Concluded from page 20)

scientific attention be given the patients. The trustees must remember constantly that every sick person in the community hampers the community efficiency and happiness—that it is uneconomic to have sickness and, when it occurs, it must be eradicated as soon as it is possible to do so.

If the trustee's connection with the hospital is considered merely as a stepping-stone to better business, civic prestige or social climbing, he is a liability rather than an asset. Big names and prominent persons are wanted, of course, on any Board of Trustees, but not at the expense of efficiency. Every man on the board should "pull his own weight". The trustee should make up his mind that he has been singled out because he has the ability and the capacity to do the job and do it well. He has been selected to aid the hospital in the splendid work that it is doing and he must resolve that he will not be found a shirker but will do everything in his power to see that the sick and the injured receive better care and attention than ever before. He must become informed as to what the hospital is—what place it holds in the community—its relation to education, to the church, to industry and to the government. He must school himself in the broad fundamentals of medical practice and know what is ethical and what is unethical. He must adopt some of the physician's philosophy. He must understand what social service is and what occupational therapy is. He must cooperate with the other members of the Board in perfecting an organization and working team that will give to the commuunity its most valued possession—Good Health.

WANT ADVERTISEMENTS

Advertisements in this department, up to 50 words, set in single column, $1.50 per insertion. If set in box, single column, $2.00 per insertion.

DIETITIAN WANTED

An experienced Head Dietitian for a 300-bed general hospital in the Maritimes. Apply to Box 1236, "The Canadian Hospital", 57 Bloor Street W., Toronto, stating qualifications, references and salary expected.

STERILIZER WANTED

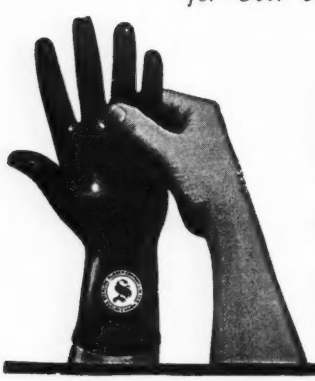
Wanted: One second-hand, electrically-heated Sterilizer, size, 16 x 24, or larger. State condition and price if cash, and also price if on terms. The Herbert Community Hospital, Alex. Gutwin, Sec.-Treas., Herbert, Sask.

STERLING GLOVES

featuring

The Best Materials that Money Can Buy

Specialists in Surgeon's Gloves for Over 31 Years.

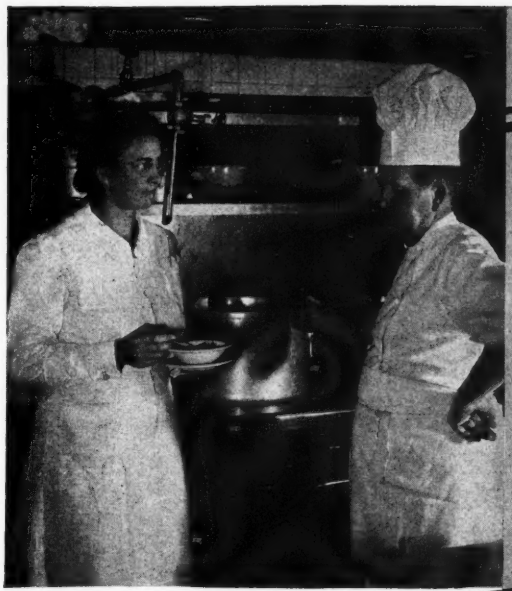


STERLING RUBBER CO.

— LIMITED —

GUELPH - ONTARIO

The STERLING trade-mark on Rubber Goods guarantees all that the name implies.



Sunfilled

DEHYDRATED SOUP BASES

...a boon to wartime cookery

Let your own palate be the judge of their delicious, full bodied flavor and goodness. Factually, preparation time of such favorites as Chicken—Beef—Pea—Bean and Bacon, is reduced from hours to minutes. You simply add a specified volume of water, bring to a boil and serve.

Sunfilled dehydrated Soup Bases effect economies in every phase of soup making. No ingredients to prepare . . . negligible fuel consumption . . . frees chef's time for other duties . . . conserves rationed meats, expensive fowl and vegetables. Carrying a full year's guarantee for freshness, Sunfilled Soup Bases can be stored without refrigeration.

Superior quality products for the economical convenience of HOSPITALS • HOTELS • SCHOOLS • CAFETERIAS • CAMPS

***ORDER TODAY** or request our representative to call for demonstration.*

CITRUS CONCENTRATES, INC.
Dunedin, Florida

Canadian Representatives: Harold P. Cowan Importers Ltd., 42 Church St., Toronto

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Have a "Coke" = Let's be friendly

...the way to win a welcome wherever you go

Where you find democracy, you find the feeling of friendliness. It's made up of little things that mark a way of life; sports, fair play, movies, and swing music. A phrase like *Have a "Coke"* turns strangers into friends, the same in both hemispheres. Around the globe Coca-Cola stands for *the pause that refreshes*—has become the high-sign of the good-hearted.

"Coke" = Coca-Cola

It's natural for popular names to acquire friendly abbreviations. That's why you hear Coca-Cola called "Coke."

THE COCA-COLA COMPANY OF CANADA, LIMITED 659

One Economical Way To Get a Better Wash!

A BETTER, cleaner, whiter wash obtained with LESS soap and bleach! That is what many hospitals and institutional laundries are getting by using specially formulated Oakite Laundry Detergents.

Try these SAFE, free-rinsing detergents for washing linens, uniforms, flatwork, patients' apparel, etc., and you, too, will find them an effective aid in stepping-up your laundering efficiency and economy!

6 Soap-Saving Formulas Free!

Available FREE for the asking from your Oakite Technical Service Representative listed below is a helpful Digest giving six formulas for saving soap and conserving bleach supplies. Write for your copy TODAY!

OAKITE PRODUCTS OF CANADA, LTD.

Technical Service Representatives:

J. J. FITZSIMMONS.....65 Front St. E., Toronto, Ont. Tel. Elgin 7655
G. W. EMPSON..1 Van Horne Ave., Montreal, Que. Tel. Crescent 1143
T. W. DAY.....1 Van Horne Ave., Montreal, Que. Tel. Crescent 1143
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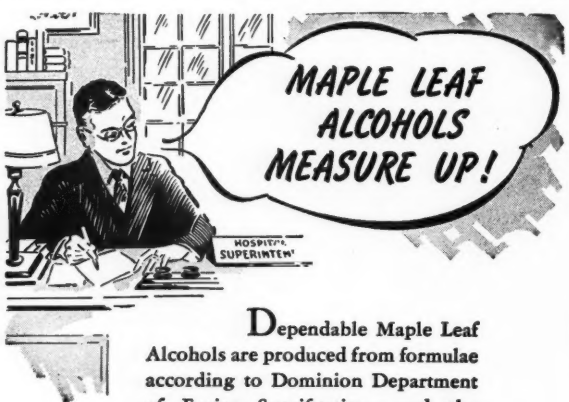
OAKITE Specialized **CLEANING**

MATERIALS METHODS SERVICE FOR EVERY CLEANING REQUIREMENT



Dependable Maple Leaf Alcohols are produced from formulae according to Dominion Department of Excise Specifications and the British Pharmacopoeia.

These fine products of careful manufacture are tested precisely from raw materials to finished products.

MAPLE LEAF ALCOHOLS Medicinal Spirits, Iodine Solution, Absolute Ethyl B. P., Rubbing Alcohol, Denatured Alcohol, Anti-freeze Alcohol, Absolute Methyl.

CANADIAN ALCOHOL **INDUSTRIAL CO. LIMITED**

Montreal Toronto Corbyville
Winnipeg Vancouver

Index of Advertisers

FEBRUARY, 1944

SURGEONS'
Operating Room Apparel

in Standard Style, or to Specifications

Style No. 356

This one piece garment (no buttons required) is in great demand for Surgeons' work.

The adjustable tie tape belt and one piece features alone, commend its use. Made from best quality bleached suiting.

Stocked in even sizes, 34-44. Priced at $25.20 doz. or $3.00 each (single).

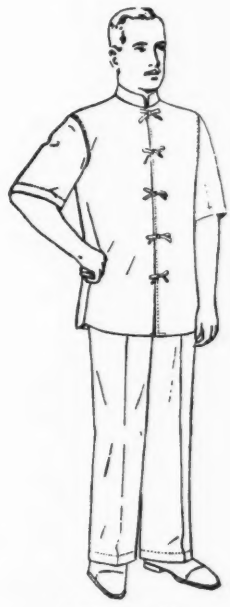
Style No. 431
SURGEON'S OPERATING GOWN

OPERATING GOWNS

Can be supplied with knitted cuffs @ $1.50 per doz. extra which fit closely and easily into the rubber gloves.

Material Number	Description	Per Doz.
99	Best Quality Unbleached Sheeting	$15.60
55	High Quality Bleached Sheeting	18.00
56	Bleached Suiting	19.80
104	Unbleached Suiting	16.20

Prices subject to change without notice.



Style No. 132
SURGEON'S OPERATING COAT

Made of Bleached Marble Head, closed down front with tie tapes. Price $15.20 per doz.

SURGEON'S OPERATING PANTS

Style No. 311

Made of Bleached Marble Head, pyjama style, draw tape at waist. Price $13.20 per doz.

Sales tax is NOT included in quotations, as same does not apply when garments are shipped to Approved Hospitals under their purchase orders bearing the required Sales Tax exemption certificate.

All garments unconditionally guaranteed, as to both workmanship and material.

MADE IN CANADA BY

SEND FOR OUR CATALOGUE

CORBETT-COWLEY
Limited

SAMPLES OF MATERIALS SENT ON REQUEST

284 ST. HELENS AVE., TORONTO — **424 ST. HELENE ST., MONTREAL**

HOFFMAN EQUIPMENT HAS GONE TO WAR

BUT—THIS 4-WAY SERVICE PLAN WILL HELP YOU

KEEP 'EM RUNNING!

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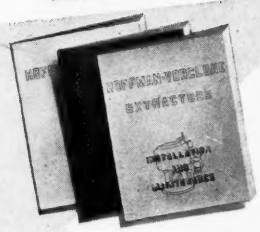

3. REPLACEMENT PARTS

4. EXPERIENCED SERVICEMEN

With few exceptions, your present laundry equipment must last for the duration. During this period, you'll find the Hoffman organization on its toes to help you "Keep 'em Running." Use our facilities whenever you need them. They stand behind every Hoffman-equipped hospital laundry.

CANADIAN HOFFMAN MACHINERY CO., LIMITED

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION -- *Made in Canada*

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Toronto, Ontario